

THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
CENTERS FOR DISEASE CONTROL AND PREVENTION
NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

convenes the

TWENTY-THIRD MEETING

ADVISORY BOARD ON

RADIATION AND WORKER HEALTH

The verbatim transcript of the Meeting of the
Advisory Board on Radiation and Worker Health held at the
Red Lion Hotel, 802 George Washington Way, Richland,
Washington, on April 20, 2004.

C O N T E N T S

April 20, 2004

REGISTRATION AND WELCOME	
Dr. Paul Ziemer, Chair.11
Mr. Larry Elliott, Executive Secretary	16
REVIEW AND APPROVAL OF DRAFT MINUTES, MEETINGS 21, 22	
Dr. Paul Ziemer, Chair	16
PROGRAM STATUS REPORT	
Dr. Jim Neton, NIOSH.26
STATUS AND OUTREACH - DEPARTMENT OF LABOR	
Mr. Pete Turcic, DOL.54
STATUS REPORT - DOE	
Mr. Tom Rollow, DOE.	77
SITE PROFILE STATUS, USE IN DOSE RECONSTRUCTIONS, AND	
ROLL-OUT, Dr. Jim Neton, NIOSH113
RESEARCH ISSUES STATUS	
Mr. Russ Henshaw, NIOSH.155
INTRODUCTION	
Dr. Paul Ziemer, Chair.	191
PUBLIC COMMENT.	198
ADJOURN.262
COURT REPORTER'S CERTIFICATE.	263

TRANSCRIPT LEGEND

The following transcript contains quoted material.
Such material is reproduced as read or spoken.

In the following transcript a dash (--) indicates an unintentional or purposeful interruption of a sentence. An ellipsis (. . .) indicates halting speech or an unfinished sentence in dialogue or omission(s) of word(s) when reading written material.

In the following transcript (sic) denotes an incorrect usage or pronunciation of a word which is transcribed in its original form as reported.

In the following transcript (phonetically) indicates a phonetic spelling of the word if no confirmation of the correct spelling is available.

In the following transcript "uh-huh" represents an affirmative response, and "uh-uh" represents a negative response.

In the following transcript "*" denotes a spelling based on phonetics, without reference available.

In the following transcript (inaudible) signifies speaker failure, usually failure to use a microphone.

In the following transcript (off microphone) refers to

microphone malfunction or speaker's neglect to depress "on"
button.

P A R T I C I P A N T S

(By Group, in Alphabetical Order)

BOARD MEMBERS

CHAIR

ZIEMER, Paul L., Ph.D.
Professor Emeritus
School of Health Sciences
Purdue University
Lafayette, Indiana

EXECUTIVE SECRETARY

ELLIOTT, Larry J.
Director, Office of Compensation Analysis and Support
National Institute for Occupational Safety and Health
Centers for Disease Control and Prevention
Cincinnati, Ohio

MEMBERSHIP

ANDERSON, Henry A., M.D.
Chief Medical Officer
Occupational and Environmental Health
Wisconsin Division of Public Health
Madison, Wisconsin

ANDRADE, Antonio, Ph.D.
Group Leader
Radiation Protection Services Group
Los Alamos National Laboratory
Los Alamos, New Mexico

DeHART, Roy Lynch, M.D., M.P.H.
Director
The Vanderbilt Center for Occupational and Environmental
Medicine
Professor of Medicine
Nashville, Tennessee

ESPINOSA, Richard Lee
Sheet Metal Workers Union Local #49
Johnson Controls
Los Alamos National Laboratory
Española, New Mexico

GIBSON, Michael H.
President
Paper, Allied-Industrial, Chemical, and Energy Union
Local 5-4200
Miamisburg, Ohio

GRIFFON, Mark A.
President
Creative Pollution Solutions, Inc.
Salem, New Hampshire

MELIUS, James Malcom, M.D., Ph.D.
Director
New York State Laborers' Health and Safety Trust Fund
Albany, New York

MUNN, Wanda I.
Senior Nuclear Engineer (Retired)
Richland, Washington

OWENS, Charles Leon
President
Paper, Allied-Industrial, Chemical, and Energy Union
Local 5-550
Paducah, Kentucky

PRESLEY, Robert W.
Special Projects Engineer
BWXT Y12 National Security Complex
Clinton, Tennessee

ROESSLER, Genevieve S., Ph.D.
Professor Emeritus
University of Florida
Elysian, Minnesota

AGENDA SPEAKERS

(in order of appearance)

Dr. Jim Neton, NIOSH

Mr. Pete Turcic, DOL

Mr. Tom Rollow, DOE

Dr. Jim Neton, NIOSH

Mr. Russ Henshaw, NIOSH

STAFF/VENDORS

CORI HOMER, Committee Management Specialist, NIOSH
STEVEN RAY GREEN, Certified Merit Court Reporter

AUDIENCE PARTICIPANTS

DAY

CARY, ANNETTE
COLLEY, ROBERT G.
DEHART, JULIA
EBY, KRISTIN
ELDER, DIANA
ELDER, ROBERT D.
KUDING, SYLVIA
LOVE, MARGUERITE E.
MAST, VERN
OLSON, JOYCE
RINGEN, KNUT
SCHAEFFER, D. MICHAEL
SMITH, ROBERT L.
STALEY, KENNETH D.
TOOHEY, DICK
TRENT, FRANK
WILLIS, T.L.

AUDIENCE PARTICIPANTS

EVENING

ADAMS, HUGH
AMADOR, ROBERT
BARKER, DIRK
BATES, CHARLES R.
BEECROFT, DONNA ALLRED
BERENETT, ROSE S.
BERGSTROM, AGNES
BIERLONI, THEO K.
BONE, SYLVIA
BOOKER, GARY P.
BROWN, E.B.
BROWN, PAUL
CHAMBERLAIN, TAPLEY B.
CHAMBERS, DONNA
CLAPHAN, F.D.
COLLEY, BOB
COOK, BETTY G.
DAUGHERTY, DOUGLAS C.
DAVID, JOHN
DUNCAN, HEATHER
EBY, KRISTIN
FESHUM, VIRGINIA P.
FLEMING, R.M.
HALSTEAD, CHARLES M.
HARRISON, B.W.
HAYS, CAROL
HARTLEY, DAN R.
HENNING, MICHAEL E.
HENSLEY, JANEL
JAHNKE, LOUISA
JARMSON, E.R.
KNIGHT, LAURA M.
KNOWLES, RANDY
KOLEBER, MARGARET
LEDFORD, CLIFF AND PEGGY
LEWIS, MARK
LILLION, ERIC
LOZIER, VERNON W.

LOZIER, VIRGINIA R.
MANUEL, MR. AND MRS. JAMES L.
MARTIN, KEITH A.
MASTROGIUSEPPE, RON
MCCALLUM, ROBERT
MERCER, CHRIS
MILLER, RICHARD
MITCHELL, C.J.
MOORE, CHARLES W.
MORSE, ROCCO J., SR.
MULLEN, LOIS
MYERS, CHESTER B.
NEWBILL, MATT
OGLESBEE, GAI
O'NEILL, ED
OVERSTREET, ROBERT W.
PATRICK, LINDA FOR LAURENCE PATRICK
PHILLIPS, CHESLEY W.
PHILLIPS, NATHAN
PIERCE, BRENDA PRINGLE
POWAUKEE, SHIRLEY
RAY, VELMA
RICHMOND, OLDEN
RUGGLES, ROBERT
SAMSON, E.R.
SCHNECK, LESTER
SHATELL, CHARLES W.
SMITH, MARY S.
STALEY, KEN
THOMPSON, BARBARA J.
TORRES, HENRY B.
TRENT, FRANK
UNDERWOOD, DAVID H.
VAN DYKE, KATHY
WALLACE, STEVEN L.
WALLACE, VIRGINIA
WELCH, MERLAINE E.
WERST, KENNETH E.
WILLIAMS, ROSIE LEE
WILLIAMSON, JIM
WILLIAMSON, NINA
YATES, ROY

1 shuffled things around. It helps keep the Board alert,
2 you know.

3 We would like to remind everyone, including Board
4 members, to please register your attendance. There are
5 registration books in the back on the table. If you've
6 not already done that, please do that sometime yet this
7 morning.

8 Also, for members of the public who wish to
9 address the Board, there's a sign-up sheet there. You
10 may realize that as you look at the agenda that we have
11 set aside an evening session at 7:00 p.m. this evening
12 here for -- devoted to public comment, and you're
13 welcome to sign up for that. If the agenda permits
14 during the daytime hour here -- and we have a number of
15 members of the public here -- we might be able to
16 squeeze in some comments even earlier than that for
17 those who might be interested before the afternoon
18 session is over. I can't guarantee that; we'll see how
19 things go. But if we have time, we may be able to
20 permit some public comment as well this afternoon.

21 There are also handouts on the table to my right.
22 This includes not only the agenda, but various
23 presentation materials that are being utilized by some
24 of our speakers today, as well as various documents
25 involved with past actions of this Board that might be

1 of interest to you. So please avail yourselves of any
2 of those that you think might be of interest to you.

3 We're pleased to have with us today some special
4 guests. Well, you're all special, but we do want to
5 recognize a couple of individuals. Shawn Bills, who is
6 with Senator Patty Murray's office -- and Shawn is over
7 here (indicating), and then Joyce Olson, who's chief of
8 staff for the tri-cities office for Congressman Doc
9 Hastings. Joyce is here and Joyce, being a local
10 person, has agreed to give us a few words of welcome,
11 as well. So Joyce, the podium is yours.

12 **MS. OLSON:** Good morning, everyone. On behalf of
13 Congressman Doc Hastings, welcome to the tri-cities.
14 Welcome to a special corner of this world. Your fellow
15 Board member, Wanda Munn, invited Doc to be here today
16 to greet you in person, and first of all, you should
17 know that Doc (sic) is well-known in this community as
18 a leader and she's held in high regard for her service
19 to the city of Richland and organizations like Girl
20 Scouts of America and also on a committee called
21 Citizens for Medical Isotopes that promotes the use of
22 medical isotopes for the treatment and diagnosis of
23 cancer. And so Doc considers Wanda to be a very
24 knowledgeable person and appreciates her expertise on
25 issues especially pertaining to the nuclear industry.

1 So Wanda invited Doc and Doc is very sorry he couldn't
2 be here in person to say hello to Wanda and to extend a
3 special welcome to each of you, but I have the pleasure
4 of doing that on his behalf.

5 To make your visit here a little bit more
6 intriguing as you're doing your work, I just wanted to
7 share a few local factoids with you.

8 Did you know the tri-cities is situated in one of
9 the world's most productive and diversified
10 agricultural growing regions? Perhaps last night you
11 had a chance to sample some of the wines produced in
12 this region. Everything from apples and asparagus to
13 mint and grapes and potatoes and alfalfa is grown here
14 in abundance.

15 And did you know that this region had two very
16 special visitors about 200 years ago, Lewis and Clark,
17 and they were part of the corps of discovery expedition
18 dispatched by President Thomas Jefferson, and they came
19 through and explored this region. And in a book
20 written by Walter (Inaudible) and also referred to in
21 Lewis and Clark's journals, they mention that when
22 Lewis and Clark camped at the confluence of the Snake
23 and Columbia River, they were greeted by 200 men
24 singing and beating their drums. I think you'll find
25 my greeting to you a little bit far less dramatic, but

1 I hope that some day you can explore our Native
2 American heritage and early history.

3 Did you know that the towns in this area,
4 particularly Richland, are the legacy of the secret
5 Manhattan Project developed during World War II to
6 produce plutonium for our nation's first atomic bomb?
7 And actually that's a fact you probably do already
8 know, and on that note, I'd like to tell you that
9 Congressman Hastings is very interested in the work
10 that you are doing. It's important to promote and
11 encourage healthy and safe workplaces. And in looking
12 back at Hanford and the number of workers that worked
13 at Hanford during World War II and on the Cold War
14 effort, he recognizes that many of them possibly
15 suffered from exposures. And he has acknowledged that
16 our nation has the responsibility to aid in the care of
17 those who suffered during their service at Hanford.

18 Lastly, Congressman Hastings appreciates the
19 progress that you're making in dealing with some of
20 these very tough and sensitive and emotional issues.
21 And finally, it is his sincere hope that your meeting
22 here in Richland today and tomorrow is very productive
23 and informative. Thank you very much, and welcome.

24 (Applause)

25 **DR. ZIEMER:** And thank you, Joyce, for that

1 welcome to all of us here today.

2 We're going to now proc-- oh, I almost
3 overlooked our distinguished Executive Secretary, Larry
4 Elliott, who usually has an opportunity also to
5 officially greet us at this point. Larry?

6 **MR. ELLIOTT:** Thank you, Dr. Ziemer. On
7 behalf of the Secretary Thompson, Department of Health
8 and Human Services; Dr. John Howard, the director of
9 NIOSH, I'd like to welcome the Board to Richland. And
10 to the public, we welcome you to this meeting. We
11 think it's very beneficial and informative. We hope
12 that the public finds the work of the Board to be such
13 and to find how the Board does its work in this open
14 public setting. We look forward to a productive and
15 informative two days. Thank you.

16 **REVIEW AND APPROVAL OF DRAFT MINUTES**

17 **DR. ZIEMER:** Thank you, Larry. We're now
18 going to proceed with the agenda as you have it in your
19 booklets, the first items being the review and approval
20 of draft minutes. We have two sets of minutes to
21 review and approve today. One is for our meeting --
22 the 21st meeting which was held in Augusta, Georgia on
23 February 5th and 6th, 2004. And then the second one is
24 the 22nd meeting, which was actually a telephone
25 conference call meeting held March 11th, 2004.

1 The minutes of the Augusta meeting were
2 distributed to the Board members about a week ago so
3 that they would have an opportunity to read them before
4 they came to the meeting. Our Board minutes, I might
5 point out -- particularly for members of the public --
6 are rather extensive. They include more than simply
7 the actions of the Board, but they do give a fairly
8 detailed summary of the discussions so that you have
9 context for the various things that were done. So for
10 example, this last set of minutes comprises somewhat
11 over 50 pages. In fact, one could argue that it was a
12 good thing we left the page numbers off so the Board
13 members didn't realize how long they were. But we will
14 instruct our keepers of the minutes next time to
15 include page numbers so that we have a little easier
16 time tracking where changes may need to be made.

17 But with that being said, let me now call for
18 any additions or corrections to the minutes of the
19 February meeting held in Augusta, Georgia. And again
20 we are looking for substantive changes. If you have
21 minor typographicals, you can pass those on to Cori or
22 to me later. Dr. Roessler?

23 **DR. ROESSLER:** On the second page of the
24 Executive Summary, right at the top, this was a summary
25 of Pete Turcic's talk. There's a very impressive

1 number there, \$742 million. I think that that needs
2 more detail because I think that number refers to more
3 than just radiation compensation. And I looked later
4 in the rest of the minutes and I couldn't find any
5 detail later on on that.

6 **DR. ZIEMER:** Yes, this --

7 **DR. ROESSLER:** Do you see where I'm --

8 **DR. ZIEMER:** -- this is the Department of
9 Labor report and could -- you're asking for a
10 clarification of that number or --

11 **DR. ROESSLER:** Well, I think it could be
12 misleading since -- I think it's probably not just
13 radiation compensation.

14 **DR. ZIEMER:** It's not -- it's not the number
15 for payouts from the portion of the program that -- for
16 which this Board is responsible.

17 **DR. ROESSLER:** And since the minutes are
18 related to this, I think we need another line in there
19 explaining that.

20 **MR. ELLIOTT:** You are correct. I don't
21 believe that -- I think Mr. Turcic stepped out, but I -
22 - this number, \$742 million, is for beryllium,
23 silicosis, the SEC cancers and cancers that have been
24 dose reconstructed.

25 **DR. ZIEMER:** So can we agree that we will ask

1 that that clarification be added to the minutes? We'll
2 put the proper words in there, basically to describe
3 what Larry Elliott has just said and we will make that
4 correction. Okay.

5 Dr. Andrade?

6 **DR. ANDRADE:** If we move beyond the summary
7 section and just into the actual minutes themselves, on
8 the OCAS program status report -- let's see, one, two -
9 - three pages in there's a comment made by myself noted
10 about halfway down the page, starts that I noted that
11 while I was anxious to see the SEC rule completed, et
12 cetera, et cetera -- it goes on to say that it has
13 nothing to do with dose reconstruction except for the
14 fact that the rule proclaims that if dose
15 reconstructions cannot be done -- and I think some
16 words were left out -- parties might be eligible to
17 apply for SEC status. I think those words would change
18 the entire context of that statement.

19 **DR. ZIEMER:** Does everyone see the paragraph
20 that's being referred to? (Reading) Dr. Andrade noted
21 that while he's anxious to see the SEC rule completed,
22 it has nothing to do with dose reconstructions except
23 for the fact that the rule proclaims that -- and then
24 you're asking that it say if?

25 **DR. ANDRADE:** That if -- and then dose

1 reconstructions cannot be done as stated there --

2 **DR. ZIEMER:** Uh-huh.

3 **DR. ANDRADE:** -- parties might be eligible to

4 appeal for SEC status.

5 **DR. ZIEMER:** And then what about the rest of

6 the sentence there?

7 **DR. ANDRADE:** The rest of the sentence

8 stands.

9 **DR. ZIEMER:** So that he doesn't see any

10 connectivity... Okay. Is there any objection to

11 adding this clarification phrase that Dr. Andrade's

12 suggested?

13 (No responses)

14 **DR. ZIEMER:** Without objection, we'll make

15 that correction.

16 Any others? Dr. Roessler?

17 **DR. ROESSLER:** This is a bit difficult

18 without page numbers, but under site profile updates,

19 when Dr. Neton was talking -- it's maybe ten pages into

20 the minutes.

21 **DR. ZIEMER:** Main topic, site profile

22 updates?

23 **DR. ROESSLER:** Right, now go back --

24 **DR. ZIEMER:** It starts on the left side of

25 the double page. Right?

1 **DR. ROESSLER:** Now I'm looking at the
2 minutes. Mine are not --

3 **DR. ZIEMER:** Oh, okay.

4 **DR. ROESSLER:** Anyway, but then go back about
5 four pages -- and of course this is one of my favorite
6 topics --

7 **DR. ZIEMER:** Back toward the front or --

8 **DR. ROESSLER:** No, toward the back, go four
9 more pages --

10 **DR. ZIEMER:** All right.

11 **DR. ROESSLER:** A paragraph that starts with
12 occupational medical dose, and you recall that that is
13 one of my favorite topics.

14 **DR. ZIEMER:** Yes.

15 **DR. ROESSLER:** When you find it, I'll tell
16 you what my question is.

17 Okay, in the middle of that paragraph it says
18 an X-ray is taken with a collimated beam. Other organs
19 not in the field of view would be irradiated, and I
20 think that's probably true. I mean I think that's what
21 was said, but I wonder if that might be confusing
22 because it would seem to me that other organs not in
23 the field of view would not be irradiated.

24 **DR. ZIEMER:** Well, technically that's
25 certainly correct, they would possibly received some

1 scatter radiation, but this --

2 DR. ROESSLER: I think maybe this sentence --

3 DR. ZIEMER: This is summarizing what Dr.

4 Neton said. An X-ray is taken with a collimated beam.

5 Other organs not in the field --

6 DR. ROESSLER: ... of view might -- I think

7 it means that it might be included, to be claimant-

8 friendly, or something along that line, because we

9 talked last time about --

10 DR. ZIEMER: Well, Dr. Neton is here, maybe

11 he can clarify -- were you referring to scatter here

12 or...

13 (Pause)

14 DR. NETON: Okay, let me just get my bearings

15 here. An X-ray taken with a collimated beam -- other

16 organs not in the field of view would be irradiated.

17 That's true, even if they had a collimated beam, there

18 would be scatter and would irradiate the organs, so

19 that statement is true.

20 DR. ZIEMER: Right.

21 DR. ROESSLER: That's what I suspected.

22 DR. ZIEMER: So that's what you're referring

23 to?

24 DR. NETON: Yes, that's what I was referring

25 to, scatter radiation from -- from even a well-

1 collimated beam would have scattered radiation in the
2 body.

3 **DR. ROESSLER:** Maybe just to --

4 **DR. ZIEMER:** So other organs in the field of
5 view would still be irradiated from scatter.

6 **DR. ROESSLER:** Due to scatter.

7 **DR. NETON:** Due to scatter.

8 **DR. ROESSLER:** I guess I'd say might still be
9 irradiated due to scatter.

10 **DR. NETON:** Correct.

11 **DR. ROESSLER:** Okay.

12 **DR. ZIEMER:** So the proposed change then
13 would be might be irradiated due to scatter -- simply a
14 technical clarification. Thank you very much.

15 Tony, you have another one?

16 **DR. ANDRADE:** Right. One double page over,
17 same section, near the top of the page. There was a
18 question that I asked about -- I asked it of Dr. Neton
19 and it says Dr. Neton referred to whether -- Dr. Neton
20 referred to natural. He meant whether it was processed
21 in its natural form. It's -- processing it naturally
22 does not make any sense.

23 **DR. ZIEMER:** He meant -- insert the word
24 "whether"?

25 **DR. ANDRADE:** Whether it --

1 **DR. ZIEMER:** Was --
2 **DR. ANDRADE:** -- was processed --
3 **DR. ZIEMER:** In its natural form.
4 **DR. ANDRADE:** -- in its natural form.
5 **DR. ZIEMER:** As opposed to processed
6 naturally.
7 **DR. ANDRADE:** Right.
8 **DR. ZIEMER:** Any objection to that
9 clarification?
10 (No responses)
11 **DR. ZIEMER:** Thank you. Without objection,
12 we'll make that change. Others?
13 (No responses)
14 **DR. ZIEMER:** If there's no changes, we can
15 have a formal motion to approve the minutes as
16 corrected.
17 **DR. ROESSLER:** So moved.
18 **MR. PRESLEY:** Second.
19 **DR. ZIEMER:** Moved and seconded to approve
20 the minutes as corrected. Any final comments or
21 discussion?
22 All in favor, aye?
23 (Affirmative responses)
24 **DR. ZIEMER:** Any opposed, no?
25 (No responses)

1 **DR. ZIEMER:** Any abstentions?
2 (No responses)
3 **DR. ZIEMER:** No, okay. Dr. DeHart, do you
4 have a comment?
5 **DR. DEHART:** We have been changing format of
6 the minutes almost continuously. I would urge that we
7 hold to his format. It's the easiest to read and to
8 follow and I commend this document.
9 **DR. ZIEMER:** You like it without the page
10 numbers, is that -- with page numbers, if we could. So
11 noted.
12 Is that -- that's Dr. DeHart's view, but
13 others like some other version better? It appears not.
14 Thank you.
15 If we can turn to the 22nd meeting, these
16 minutes you did not have in advance. This is a summary
17 of the telephone call. It's a single topic discussion.
18 These are very brief; however, if you have not had a
19 chance -- well, you got your packet last night. If you
20 did not have a chance to read these, the Chair is
21 willing to have action deferred until tomorrow. I'd
22 point out, however, this is a very short set of
23 minutes.
24 **MS. MUNN:** I'd appreciate tomorrow.
25 **DR. ZIEMER:** We can delay till tomorrow.

1 Others -- okay, it seems to be a consensus that we
2 delay action on those meetings unt-- or minutes until
3 tomorrow, and we will take those up during the
4 housekeeping session in the morning.

5 **PROGRAM STATUS REPORT**

6 We'll go ahead then with the next item on the
7 agenda which is the program status update. Jim Neton
8 is going to make that presentation.

9 **DR. NETON:** Thank you, Dr. Ziemer. Is
10 that --

11 **DR. ZIEMER:** Is that a rheostat behind you
12 there? Can we lower the --

13 **DR. NETON:** There's a lot of them. Is that
14 too low? Okay.

15 Thank you, Dr. Ziemer. It's my pleasure to
16 be here in Richland to present the NIOSH program
17 statistics -- appreciate the nice weather that was
18 arranged for us to be here. The last time I was here,
19 in January, I think we had ten inches of snow on the
20 ground, which is unusual around here.

21 This is the standard format -- or standard
22 presentation that you've received over the last few
23 Board meetings, but it's gotten a little bit of a
24 facelift and I think you'll find there's more graphics
25 in here, a little prettier to look at, anyway, and

1 organized a little differently, and maybe a slide or
2 two that you haven't seen before.

3 The first slide shows the number of cases
4 that have been referred to us from the Department of
5 Labor. This is as of April 15th. We've popped over
6 the 16,000 mark, so we're steadily increasing. The
7 proportions from the different district offices of the
8 Department of Labor are remaining fairly constant. We
9 have about two-thirds of the claims from Seattle and
10 Jacksonville combined, and Cleveland and Denver
11 constitute about a third of the other claims. Of
12 course Seattle and Jacksonville encompass some of the
13 major DOE facilities such as Savannah River, Hanford
14 and the Oak Ridge reservation, which largely accounts
15 for the number of claims we're seeing in that -- in
16 those district offices.

17 This is a histogram that shows the cases
18 received by quarter from the Department of Labor. As
19 you can see, we popped at almost -- over 2,900 claims
20 in the summer of -- end of the summer of calendar year
21 2004 and have been dropping steadily down to around 200
22 claims a week on average right now, although I think
23 we're -- pardon?

24 **MR. ELLIOTT:** 2002.

25 **DR. NETON:** 2002, yeah -- 2002, I'm sorry.

1 And we're seeing about 200 claims a week coming in the
2 last month of the quarter for -- quarter three in '04
3 is just for the first half of April statistics, so
4 that's why the numbers seem so low. We expect that
5 that will be at least as equal to quarter two after the
6 end of the month is over.

7 This slide depicts the number of requests we
8 sent out to the Department of Labor -- I mean
9 Department of Energy. We've sent out 15,373 requests
10 that represent 13,897 cases. The number of requests of
11 course exceeds the number of cases because we have
12 multiple work histories for a number of our claimants.
13 The other thing I'd point out is even though we have
14 16,000 cases in-house, a couple thousand of those are
15 from Atomic Weapons Employer sites, therefore the
16 number is lower. We're fairly -- we keep fairly close
17 with the requests for information to the Department of
18 Energy. There's rarely a one or two-week backlog in
19 getting those requests out to -- to Energy. So if you
20 add the 2,000 AWE claims which we don't request
21 information from Energy for most of the cases, we're
22 right around 16,000 -- pretty close.

23 We've received 14,711 responses, representing
24 over 13,000 cases.

25 We do request that we receive a response from

1 the Department of Energy within 60 days. If they
2 cannot provide a response within 60 days, we ask that
3 they notify us and provide a reason why that response
4 can't be met. And we've had a fairly good
5 relationship, as you know over past Board meetings, in
6 getting these responses in from Labor -- or Energy.
7 They've been quite responsive. We do show some claims
8 that are outstanding over 60 days, and in fact we have
9 a few -- a few, actually 114 -- that are over 150 days.
10 Those claims -- we're working with Energy on those to
11 try to move those forward. They typically represent
12 claims that are either very early in the process -- you
13 know, late '40's or even mid-'40's -- or have some
14 bioassay records, particularly for internal dosimetry,
15 that we're trying to capture that don't exist in
16 retrievable form. They're either in databases or
17 something to that effect where we actually need to --
18 they need to write a little database to get them to us.
19 But we're working very closely. We do put out a
20 monthly report to Energy informing of their performance
21 and coordinate our effort to make sure that we both
22 agree as to which claims are still outstanding.

23 Telephone interviews I think has been a
24 fairly successful program. ORAU has done an excellent
25 job at keeping up with these interviews. We've done

1 13,127 interviews for -- at least one interview per
2 case. Many cases have multiple interviews required
3 because there are multiple claimants per case. And
4 we've sent some reports out to 12,000 -- almost 12,300
5 drafts to the claimants.

6 The capacity of 200 to 300 is well in place.
7 The interview process is not the pinch point in this
8 process at all, and I think it's a fairly well-running
9 machine at this point.

10 This is a histogram of the number of
11 interviews done by month since 2002. And as you can
12 see, it's sort of an inverse of the number of claims
13 received from Labor. Where in Labor we had the big
14 bolus here and then going down, you can see that we're
15 going up. It's kind of like a reverse lognormal
16 distribution. But you can see we've had months where
17 we've done over 1,700 interviews.

18 This is the statistics for where we are in
19 the dose reconstruction process. We have 4,338 claims
20 staged for dose reconstruction. And what that means is
21 that the claimant has received a letter notifying them
22 of one of the select-- one of the -- from ORAU telling
23 them that their dose reconstructor will be assigned.
24 We also have received some response from the Department
25 of Energy indicating that there is some available

1 exposure information. And most often the site profile
2 for that site has been done, or some other technical
3 document that would allow us to move the dose
4 reconstruction forward.

5 We also have -- this is a cumulative process,
6 so there's 4,338 staged. There's also 1,020 that have
7 been assigned to dose reconstructors. That means that
8 a dose reconstructor has physically been assigned.
9 There's a name attached to that file and it's in the
10 person's queue to be done. These claims are what we
11 call our hoppers. We fill the hoppers, ready to move
12 out, and they would be the next -- they would -- these
13 would be very close to having completed dose
14 reconstructions.

15 We've sent out over 2,700 draft reports to
16 claimants, of which 2,319 -- well, we sent 2,714 and
17 we've sent 2,319 finals to the Department of Labor.
18 The disconnect here is that we require the OCAS-1 form
19 to be signed before we can move it to the Department of
20 Labor. That can take time. A claimant has up to 60
21 days to sign the OCAS-1, so there's always a slight lag
22 between the number that we have in the hands of the
23 claimants and the number that are in Department of
24 Labor. In some cases where you have multiple
25 claimants, there may be ten claimants per case, it

1 takes some time to accumu-- do all the close-out
2 interviews and acquire the OCAS-1 forms.

3 This is just a histogram that shows our
4 production by month. And you can see within the last
5 year, starting in April of last year, those 2,700
6 claims have been put -- most of those have been put out
7 in the last 12 months. Our production is increasing.
8 The month of April of course is not complete. We're
9 optimistic that this histogram will exceed the March
10 production goals. We're working very hard to do that.
11 And I think -- if you can bear with my imagination, I
12 think you can see a nice trend going upwards. I might
13 argue that a linear quadratic equation could be fit to
14 that. But we are -- we are moving forward and moving
15 towards our goal of 200 dose reconstructions per week.

16 The final dose reconstruction reports, as I
17 indicated, should mirror the drafts that go out, the
18 only difference being the waiting on the OCAS-1's to be
19 signed -- close-out interviews and the OCAS-1's being
20 forwarded to Labor. So this fairly closely mirrors our
21 experience with the drafts going out the door.

22 This is a new slide I don't think you've seen
23 before. It might need a little explanation. The X
24 axis here is claimant number. As you may know, we
25 assign every claimant a unique I.D. number starting

1 from claimant 1 and moving out through claimant 16. So
2 what this portrays in blocks of 1,000 is how many
3 claims we've done per block of 1,000 claims. So we've
4 done 253 dose reconstructions out of the first 1,000
5 claims we received.

6 I think it's interesting to see that the
7 slope does tend to go in the right direction, that
8 being that we are concentrating efforts to move out
9 claimants earlier in the process when we can. However,
10 we also have a policy that if a claim can be done and
11 processed with the information that we have at hand,
12 we're not going to hold them up, either. So that's why
13 you see a fair number of these being done, as well.
14 But in general, I think the trend shows our efforts to
15 try to move the earlier claims out in a priority
16 manner.

17 This is a little busy, I suppose, but it's
18 really a combination of the three histograms I showed
19 before, this being the number of claims that we've
20 received from the Department of Labor, the orange or
21 reddish line -- or the yellow line is the draft dose
22 reconstructions sent to claimants, and the red line is
23 the final dose reconstructions sent to the Department
24 of Labor. I like to look over in this area where I
25 think in the month of -- two months, February and

1 April, I believe, we actually exceeded the number of
2 claims going back to Labor than we received from them.
3 So in a small way, we're starting to reduce the backlog
4 of claims that are in our possession. We hope that
5 this trend continues and we can rapidly start to chew
6 into the backlog a bit faster.

7 This slide depicts the administratively
8 closed analysis records that we have in-house. What
9 this means is that the number of claims that have been
10 in the hands of the claimants for more than 60 days and
11 an OCAS-1 form has not been received and the claimant
12 is not forthcoming with any additional information.
13 Per our regulations, we can administratively close the
14 dose reconstruction, send a letter to the claimant
15 notifying them that we have done so, and copy the
16 Department of Labor. At that point the Department of
17 Labor may close the case itself. So there have been a
18 number of these -- not a tremendous number, but there's
19 14 claims or cases that have -- people have received
20 administrative closure letters from us.

21 Of course the dose reconstruction is -- can
22 be reopened if the claimant signs the OCAS-1 form or
23 provides additional information.

24 Dr. Ziemer?

25 **DR. ZIEMER:** Jim, you have an extra slide on

1 your handout. Did one get skipped or --

2 **DR. NETON:** That's possible. Which one is
3 it?

4 **DR. ZIEMER:** Well, it appears just before
5 this one in our handout.

6 DR. NETON: Just before this one...

7 UNIDENTIFIED: The reworks.

8 **DR. NETON:** Oh, the reworks. Maybe -- yeah,
9 maybe the...

10 (Pause)

11 **DR. NETON:** Somehow they got swapped in the
12 computer. Okay. This is a slide that's titled
13 "Reworks". What this depicts is number of claims
14 during those time periods that have been returned to us
15 from the Department of Labor. They've been through the
16 entire process. The claimants received the draft, they
17 signed the OCAS-1, the close-out interview's done. We
18 sent it to the Department of Labor and, for a variety
19 of reasons, it comes back to us to be redone.

20 There are a number of reasons. They can
21 range from the claimant has developed an additional
22 cancer in the time period that the dose reconstruction
23 was being processed. There could be an issue with the
24 ICD-9 coding, the type of cancer coding that was on the
25 original referral. There could be differences in

1 employment dates. The claimant will look at it and
2 point out that their employment record was not exactly
3 as depicted -- those type of issue.

4 It doesn't look like a large number, but if
5 you add those all up, it constitutes about five percent
6 of our workload going back to -- that goes to Labor
7 comes back to us for a rework. We have committed and
8 negotiated this, that we would like to get these
9 reworks done within 60 days because the claimant's
10 already received it, they've signed the OCAS-1.

11 In general, it's possible for us to do that
12 because many of these reworks are adding a month or two
13 of employment or an additional cancer that isn't very
14 difficult to reconstruct. However, there are some
15 cases where there are blocks of cancers or unique
16 cancers that require -- if we'd done the efficiency
17 process, for example, for a cancer and then the claim
18 has a very low probability of causation, and then an
19 additional cancer comes in that would require us to do
20 a full analysis, it would require a lot of additional
21 work, and sometimes it's not possible for us to do
22 those in 60 days. But we do our best to get those out
23 -- out the door.

24 I think you see -- it looks like there's a
25 trend here going up, but I think this is just an

1 artifact of the number of claims we're starting to
2 process.

3 Okay. The phone calls continue to be heavy.
4 OCAS has received over 29,000 phone calls since the
5 program started. However, I've been told that since
6 we've started issuing these quarterly activity reports
7 in the mail to claimants, that has actually reduced our
8 phone burden somewhat. The claimants, after the first
9 round, got the idea of what was in -- what was -- what
10 this activity report was all about and they're able to
11 interpret it. Our phone calls have gone down somewhat.

12 ORAU has apparently -- there seems to be a
13 very large number there, over 84,000 phone calls. I
14 believe this includes the interviews that are done, as
15 well as scheduling of interviews and close-outs, that
16 sort of thing. So it includes some of that -- routine
17 operations, but nonetheless, they've taken over a large
18 burden of handling the phones. They have their own 800
19 number that the claimants are aware of and I think they
20 do a pretty good job at that.

21 E-mail continues to be popular, over 3,900 e-
22 mails we've received. We try to respond to those in a
23 timely manner. Hopefully we can answer these within a
24 day of when we receive them, sometimes a little longer
25 depending on the nature of the question.

1 Okay, recent accomplishments. Physician
2 panel -- in the area of physician panels, 40 new
3 appointments were made on April 12th to bring our --
4 NIOSH has appointed 215 total physicians for the
5 Department of Energy's activities under Subpart D.

6 Site profiles continue to be developed and
7 approved. I don't want to steal my thunder in my
8 subsequent presentation, but we have four of the major
9 DOE sites now covered with site profiles, those being
10 Savannah River, Hanford, Y-12 and Rocky Flats. And as
11 of Friday, we generated and issued the Iowa Ordnance
12 Plant site profile, which was long in coming. I'll
13 talk a little bit more in detail about that later on
14 today.

15 Quarterly dose reconstruction activity
16 reports I alluded to a little earlier. Every quarter
17 we send out an activity report that details the status
18 of the claim to each claimant. We just finished the
19 third issuance of those or third quarterly report last
20 week, and I believe we sent out over 20,000 mailings to
21 the claimants. I think that's been a very positive
22 activity.

23 The web site, if you haven't visited it
24 recently, I would encourage you to. It's been somewhat
25 redesigned. The site profile page that used to be part

1 of the dose reconstruction page now has its own page.
2 There's some explanatory text in there about what a
3 profile is and what the definition of facility is that
4 we use for those profiles, that sort of thing. There's
5 an archive page now for previous site profiles that are
6 -- have been revised. So even if we -- if we revise a
7 site profile now, all versions are still maintained on
8 the web and it can be viewed by anyone who so chooses.

9 The claimant status request is a new feature
10 we've added. We've allowed now for claimants to
11 request a status report of their claim via e-mail. If
12 they send an e-mail to the OCAS box, they will be --
13 they will receive a written response from us. We try
14 very hard to maintain claimant privacy with this
15 process, and it was not -- it was virtually not
16 possible to verify a claimant is who they said they
17 were via e-mail. That's why if you send a request and
18 we do some basic validation to make sure the person is
19 either a claimant or an authorized representative, then
20 we will send the e-mail -- the response directly to the
21 claimant or the authorized rep's home address. In that
22 case, if they haven't been the one to send in a
23 response (sic), then there's no harm done. They'll
24 receive a response that they didn't request. And we've
25 been starting to get some of those in the door and we

1 process those in a fairly quick manner.

2 The claim information page is updated
3 somewhat, and I really an excited about this update.
4 It provides some very good statistics. There's a flow
5 chart there that has six boxes that depict where we are
6 -- essentially a summary of the status that I just
7 gave; how many claims in-house, how many responses from
8 the Department of Energy, how many interviews, how many
9 back in the hands of claimants, how many at Department
10 of Labor, so it's a really nice linear flow chart that
11 depicts what the status is.

12 But what I really like is the feature that
13 you can view all claim sites. If you click on the
14 cases by covered facility, it is organized by state and
15 you can look up where we are with every covered
16 facility in each of those six boxes by site.

17 So for example, if one wanted to know where
18 we are -- we were with the Hanford claims, you could go
19 to Washington state, find Hanford and find out that we
20 have 1,865 I think claims from Hanford -- 1,875 claims,
21 233 which have been returned to the Department of Labor
22 with completed dose reconstructions.

23 It's a dynamic site. It's updated once a
24 day, so the numbers change daily. One needs to be
25 aware of that, so when you quote statistics you have to

1 be careful on what day you're quoting the statistic.

2 Okay, I think that concludes my formal
3 remarks. I'd be happy to answer any questions if there
4 are any.

5 **DR. ZIEMER:** Thank you, Jim. Let's open the
6 floor now for questions. Dr. Melius?

7 **DR. MELIUS:** Yeah, I have a couple -- about
8 three questions, to be exact. The first question
9 concerns the backlog and how -- explain a little bit
10 more how you're sort of triaging the requests. I get I
11 guess a little concerned. I was a little surprised to
12 see that one new chart you gave with the -- the group
13 of 1,000 at a, you know, time, where they were that --
14 we've got a lot of requests that are very old in there.
15 Some of the first ones that come in that aren't being
16 handled yet, and without knowing which sites they came
17 from and so forth, it's hard for me to, you know,
18 project how soon you get into those. But it -- could
19 you describe a little bit more how you're balancing
20 between doing -- assuming you're doing batches as the
21 site profiles get done, but what's happening to the
22 other cases that aren't going to get -- that are old
23 but aren't sort of covered by the site profiles or --
24 either within a facility or because you're not doing a
25 site profile on that facility for a while yet.

1 **DR. NETON:** Uh-huh, where was that -- that's
2 the one you're talking about (indicating)?

3 **DR. MELIUS:** No, no, I'm talking about the
4 one where you broke it up by -- by thousands of claims.

5 **DR. NETON:** Oh, okay.

6 **DR. MELIUS:** That one, yeah.

7 **DR. NETON:** Okay. Both slides I guess are
8 sort of connected. There are 4,000 claims that are
9 staged -- what we call staged for dose reconstruction.
10 And really that -- that's a function of where we are
11 with our technical documentation on the programs. We
12 have -- those four major site profiles for DOE
13 facilities that I mentioned constitute roughly about 40
14 percent of our cases that we can start to do. It
15 doesn't mean we can do them all, but at least we're
16 eligible now. We've got a pretty good handle on the
17 technical issues at those sites, so those are going to
18 be in the hopper, so to speak, we like to call them.

19 But we also have other technical
20 documentation that we can use. I believe at the last
21 Board meeting I talked about these complex-wide
22 approaches where we take a DOE complex-wide or an
23 Atomic Weapons Employer complex-wide where we assign
24 these very large exposures and we can move certain
25 claims through that way. Those tend to go across many

1 sites. I've forgotten the statistic now, but the last
2 time I looked, we had done dose reconstructions at 65
3 different sites. I think it's much more than that now,
4 and that's primarily a function of these complex-wide
5 documents.

6 But the bulk of the ones that you're going to
7 see move forward are the ones that are covered by these
8 -- the major site profiles. Savannah River Site, we've
9 done a large number. Hanford, we're moving forward
10 now. We expect Rocky Flats to start moving. Iowa
11 should start moving. So that's sort of how we triage
12 them.

13 **DR. MELIUS:** 'Cause if I look at this chart,
14 it looks as if you've taken the first 11,000 or so -- I
15 don't even know where the cutoff is -- and just sort of
16 treated them as one group that applied at the same time
17 and -- or just going through that process rather -- and
18 then you're sort of triaging by when they applied for
19 the most recent, you know, few thousand that have come
20 in. I guess my concern is that if we get -- as you
21 start to go through this backlog, you get -- however
22 long that's going to take, a year or more, I don't
23 know, it's hard to say -- but that you're going to be
24 left over with some people that have, you know, filed
25 claims four or five years ago and aren't being --

1 **DR. NETON:** I hear what you're saying. I
2 agree with that, but the -- the problem is, once you
3 have a site profile and you can do it, you know, we
4 will do these first because those are the older claims.
5 But however, if these can be done because we have the
6 profile, we feel that it's in the claimants' interests
7 not to hang onto it and wait until, you know, someone
8 else back here can get done. So we will move a claim
9 forward if we can --

10 **DR. MELIUS:** Uh-huh.

11 **DR. NETON:** -- given that we'll put most
12 emphasis on moving these first.

13 **DR. MELIUS:** Yeah, I guess I would just get
14 worried if we got six months down the road or a year
15 down the road and we still had 500 claims left in that
16 first 1,000 that, for whatever reasons, aren't being
17 dealt with yet. Meanwhile we've got a lot more recent
18 claims that you're going through. And I don't -- not
19 saying it's an easy answer and I'm just trying to get a
20 sense of what -- where -- where it goes and, you know,
21 what approach might be used to help that.

22 **DR. NETON:** I understand. We're very
23 sensitive to that and we -- we constantly -- I think I
24 mentioned this in past Board meetings -- are moving
25 through the claims and looking at them to see which

1 ones, you know, can -- can be done preferentially in
2 the lower numbers.

3 **DR. MELIUS:** My second --

4 **DR. NETON:** Sorry, I think Dick Toohey might
5 have an additional comment to make.

6 **DR. TOOHEY:** Dick Toohey, ORAU. I just want
7 to remind you that we do have a small group -- it's
8 only about four people, but we call them the
9 supplemental dose reconstruction team, and their
10 mission is to work on the oldest cases. They've
11 started with claim number one and if it can be done in
12 the absence of a completed site profile, they do it.

13 Also, our other efficiency process is to look
14 at some of the easily-compensable cases. For example,
15 lung cancer cases with positive lung counts for
16 transuranic inhalation. Those turn out to be pretty
17 compensable without having to do a lot of work on the
18 dose reconstruction. And most of those, also --
19 apparently, at least from what I've seen -- are some of
20 the earlier cases. So we are -- it's not a huge effort
21 on knocking out some of the oldest cases, but there is
22 some additional effort going on on that.

23 **DR. NETON:** Thanks, Dick.

24 **DR. MELIUS:** Another one of my questions
25 really may be a third part of that efficiency process,

1 which would be in Special Exposure Cohort process. Can
2 we have an update on that or is...

3 **DR. NETON:** I'll refer that question to --

4 **DR. MELIUS:** To Larry?

5 **DR. NETON:** -- Larry. I know. I know.

6 **MR. ELLIOTT:** We should just make that part
7 of the progress report and say we're not making any
8 progress.

9 Seriously, the rule has been revised
10 according to public comment, which we carefully
11 considered, and it has cleared through our Department
12 and we're waiting on clearance from Office of
13 Management and Budget.

14 **DR. ZIEMER:** Let me insert at this point that
15 I have just received a letter from Secretary Tommy
16 Thompson in reply to the letter from this Board. Did
17 we get copies of this to distribute? We just got this.
18 Why don't you go ahead and distribute that.

19 It simply says we, the Department, have
20 completed our work on the rule and its publication
21 awaits clearance by the Office of Management and
22 Budget. We realize that potentially eligible classes
23 of workers have been blocked from filing petitions to
24 become members of the Cohort, and we look forward to
25 publishing the rule shortly so that petitions may be

1 filed.

2 So I believe that's all we can say at this
3 point. This is from the Secretary of Health and Human
4 Services. You'll each get a copy of that letter and
5 copies will be available for the public, as well.

6 You had a third question though?

7 **DR. MELIUS:** I had a third question. I'm not
8 going to suggest we write a letter to OMB yet, but...

9 My third question goes back to the interview
10 process, and we had a working group that dealt with
11 some of those issues and I think we reported -- I
12 believe it was about six months ago or so, but is --
13 and I guess my question is sort of where are you in
14 some of the sort of the quality assurance steps that
15 were being -- that we recommended and I think everyone
16 sort of agreed on at the time that were sort of being
17 implemented that would allow for better -- sort of --
18 better quality control in that process as what's sort
19 of an ongoing evaluation of that process and -- this
20 may be something that we put on the agenda for the next
21 meeting or something, it's really up to you, but I
22 think it would be nice to get an update on that.

23 **DR. NETON:** Yeah, I'm not 100 percent
24 familiar with where they are with that right now. I
25 know that they've drafted some procedures. Maybe I

1 could ask Dick Toohey to inform us -- for a sentence or
2 two on that issue.

3 **DR. TOOHEY:** I should learn to sit closer to
4 the microphone. The procedures have been drafted.
5 They're in internal review. Some of them are in
6 internal review, some we've sent over to NIOSH for
7 review. We also have our internal QA group who
8 completed a semi-annual -- oh, everybody hates the term
9 "audit" so we say quality conformance assessment of our
10 operations in February, and that report is out. And
11 they also took a look at how the interview procedure is
12 working and what additional procedures or controls, if
13 any, may be needed.

14 **DR. MELIUS:** I'd just suggest that we
15 consider sort of a -- one of the -- maybe next couple
16 of meetings consider putting the interview -- sort of
17 an update on that whole process on agenda on that
18 'cause I think in terms of our review of the individual
19 dose reconstructions that would sort of be timely and
20 helpful.

21 **DR. ZIEMER:** Henry Anderson and then Robert
22 Presley.

23 **DR. ANDERSON:** Yes, I just want to commend
24 you for -- we're sort of getting into a routine on the
25 slides for tracking, and I think they're very helpful.

1 I would only add two things -- and I find this one very
2 helpful, but what you might want to do is even make it
3 more complex, which I know you've tried to simplify, is
4 one along the base there it would be helpful to know
5 what are the time frames, because 1,000, 2,000, 3,000
6 might have been in a four-week period or some of those,
7 so some sense -- I like the slides that show, you know,
8 kind of the dynamics of time, so I -- and this is
9 somewhat time, but it's also -- at times you have a
10 bolus come in, so 6,000 to 7,000 might really be a
11 arbitrary split and I wouldn't want people to think
12 that because their number is, you know, 2,001, that
13 that's somehow -- they've been waiting a whole lot
14 longer than somebody at 3,000, so that might help.

15 The other would be if you do have your staged
16 ones, you could put the bar on top so we could have a
17 sense -- not -- completed is obviously the finality,
18 but get a sense of how many in fact are moving versus
19 just sitting waiting for something else might be
20 helpful.

21 The other is the phone calls. I think that
22 would also be helpful to look at that over time or
23 spread it out in some way so -- you'd like to be able
24 to see that the load on NIOSH has been coming down at
25 the same time the others are going up, where you don't

1 get that dynamic sense from just the totals.

2 The other would be to add -- I think the web
3 site certainly has become more user-friendly providing
4 information, and it would be helpful to see the hits on
5 various components to see are claimants actually using
6 it more than they were in the past. I mean you put a
7 lot of resource into that, so you'd like to be able to
8 show that in fact that's been effective.

9 **DR. NETON:** Thank you, very good suggestions.

10 **MR. PRESLEY:** Bob Presley. Jim, on the
11 fourth slide, the age of outstanding requests, from 60
12 days to 150 days, are these outstanding requests -- are
13 they more prevalent from one site or two or three
14 sites, or are they pretty much scattered out all over
15 the AWE?

16 **DR. NETON:** You know, we used to have that
17 statistic on these slides and we took it off for this
18 one, so now you've caught me a little short. I would
19 say they're probably reflective of a few sites, some
20 sites -- I can't give you the exact details. I know
21 that at Los Alamos we have some issues with bioassay
22 results. That's when I alluded to the database issues
23 where we're working with them very closely to get the
24 data into the proper form so we can get those numbers.
25 But I honestly can't give you the statistics off the

1 top of my head which sites those are. I do suspect,
2 though, that they're some sites -- you know, some
3 selected sites that constitute the bulk of those
4 delinquent -- what I'll call delinquent requests.

5 **MR. PRESLEY:** I'm just wondering if it would
6 help -- if some of these sites -- if we put a letter
7 out asking that a little bit more attention be given to
8 helping these sites get their information in.

9 **DR. NETON:** I don't know, I guess -- I can't
10 answer that, other than I know we coordinate very well
11 with the Department of Energy. They're aware and, as
12 far as I can tell, the appropriate level of resources
13 appear to be dedicated to these efforts. It's not a
14 resource issue, I don't think. It's really
15 availability of the information.

16 **DR. ZIEMER:** Dr. Melius?

17 **DR. MELIUS:** Yeah, along those lines, I
18 believe on our -- one of the agendas -- draft agendas
19 we saw, there was a -- I think Ted Katz or someone was
20 going to give a report that had to do with access to
21 exposure -- you know, dose records and so forth. What
22 was that, Larry? I'm...

23 **MR. ELLIOTT:** That was a -- we had scheduled
24 an agenda item for this meeting to have Ted report on
25 matters that influence dose reconstruction.

1 **DR. MELIUS:** Oh, okay.

2 **MR. ELLIOTT:** This was actually a report that
3 we were asked to prepare for Congress on that subject
4 matter. We had envisioned that report would be
5 available to present to you all. We think it's very
6 educational and informative. But unfortunately, that
7 report is not available to speak from today. So
8 hopefully next meeting we'll have that.

9 **DR. MELIUS:** Okay, thanks. Could -- just --
10 it would be helpful, along Bob's question, to -- the
11 next time you present this is to -- little more
12 information on the sites that -- where there is a
13 problem and we can get a better understanding of that
14 and not put you on the spot by trying to -- making
15 someone remember where --

16 **DR. NETON:** We'll add that back next time.

17 **DR. MELIUS:** 'Cause if my memory's right, it
18 appears you -- a lot of the backlog has been cleared
19 and --

20 **DR. NETON:** Oh, yeah.

21 **MR. ELLIOTT:** We think there's a very good
22 relationship here and we're working really hard with
23 the DOE to be coordinated on this. And I think -- is
24 ETEC -- is Boeing in that mix? Is that one of those
25 sites --

1 **DR. NETON:** Yes.

2 **MR. ELLIOTT:** -- where we've got like 30 that
3 are over 150 days --

4 **DR. NETON:** Yes.

5 **MR. ELLIOTT:** -- and the issue is is that --
6 we're working with them and -- the Department of Labor,
7 Department of Energy, to make sure that they're
8 eligible in -- claimants, first of all, and then if so,
9 can we actually get out hands on the exposure records.
10 So there's a little reluctance in that regard but we're
11 working through that.

12 **DR. NETON:** I suspect there's an individual
13 story behind every one of those.

14 **MR. ELLIOTT:** And I think -- also I would say
15 that those that are over 150 days, there is an
16 individual story, there's some circumstance relevant to
17 each individual claim as to why they're that -- they're
18 overdue that long --

19 **DR. NETON:** Yeah.

20 **MR. ELLIOTT:** -- and we're working with DOE
21 on that.

22 **DR. ZIEMER:** Any further questions or
23 comments for Jim Neton?

24 (No responses)

25 **DR. ZIEMER:** Thank you. If not, we'll

1 proceed on the agenda.

2 **STATUS AND OUTREACH - DEPARTMENT OF LABOR**

3 Next we'll have the status report from the
4 Department of Labor. Pete Turcic is here today. Pete
5 -- oh, hang on just a moment. Comment from Jim Neton.

6 **DR. NETON:** I'm going to steal the microphone
7 from Pete -- we'll add back Pete's time. I forgot to
8 mention one important thing that we're working on right
9 now, and that is connected with recent accomplishments.
10 We're working to get IMBA available to members of the
11 public through our web site. We will entertain
12 requests for IMBA outputs and runs to the OCAS inbox at
13 this time. We do -- we are aware, though, that it's a
14 complex program and is going to need some assistance
15 from us, more than likely, to guide a person as to what
16 type of input we need. And we're working to that end
17 as we speak to develop a template for people to fill in
18 to request, via e-mail, outputs from IMBA. So we're
19 working very closely with Oak Ridge Associated
20 Universities to make that happen.

21 In addition, we will entertain calls to their
22 800 number for guidance as to how to submit a request,
23 as well. I don't -- we don't believe that it's
24 practical to do on-line -- on telephone with IMBA runs.
25 It's just too complicated. So we'll work with people

1 on the telephone to nail down what parameters they're
2 really interested in obtaining information for, and
3 we'll put that in writing and then we'll issue a
4 request via e-mail or regular mail, whatever --
5 whatever makes sense. We'll also of course at any time
6 entertain written requests via regular mail to our
7 office.

8 Sorry for not mentioning that, but I think
9 it's very important that I bring that up.

10 **DR. ZIEMER:** All right. Thank you. A
11 question on that.

12 **DR. MELIUS:** I believe -- this is Mark
13 Griffon's question -- (Inaudible) running out here, but
14 there was I believe a commitment to try to make -- to
15 make IMBA available to the Board members?

16 **DR. NETON:** Yes.

17 **DR. MELIUS:** Has that been resolved yet?

18 **DR. NETON:** No, not yet, but we're working
19 very diligently to work through the licensing issues.
20 I believe that we're close, but at this time a decision
21 has not been made how that will work. That's the best
22 I can say.

23 **DR. MELIUS:** How soon will we have a
24 decision?

25 **DR. NETON:** Larry, can you help me with that?

1 **MR. ELLIOTT:** As soon as we can get it to
2 you. We want it sooner. We realize that the Board
3 needs IMBA, your contractor needs IMBA, and each --
4 each of those two entities, as well as our contractor.
5 We are currently operating under a different user's
6 license agreement and we have to put all of that into
7 place. So as soon as we can work out those details --
8 we're full aware of the Board's time schedule for
9 reviewing dose reconstructions. You want to get
10 started on that, and to do that you have to have IMBA.
11 We realize that. So we're working as diligently as we
12 can to get it to you.

13 **DR. ZIEMER:** Thank you. Now, Pete.

14 **MR. TURCIC:** Thank you. It's a pleasure to
15 be here to give you a status update on the DOL portion
16 of the program.

17 The number of claims -- we're up to over
18 53,000 claims. And as you can see, the vast majority
19 now are cancer claims.

20 And here's the status. This chart gives the
21 status. It shows where -- the status of the claims in
22 the process. As you can see, there's about 15,600
23 pending at NIOSH, another 2,000 -- over 2,000 that are
24 pending action in our district offices. So those would
25 be claims that have not received a recommended decision

1 yet. One thing that's affecting that number is that
2 due to our recent efforts in enhancing our outreach,
3 our number of claims have -- received have considerably
4 gone up. For the last several months we've been
5 averaging anywhere from 250 to 300, 320 claims per
6 week. And in addition, another aspect of that is that
7 the claims are now also -- that we're looking at,
8 they're far -- far fewer percentage -- far less
9 percentage are non-covered conditions. So we -- you
10 know, the number of claims are up -- is up and so is
11 the number of claims that are covered conditions.

12 Another 1,900 are -- have a recommended
13 decision and are in the process of, you know, awaiting
14 a final decision -- either review of the record or for
15 a -- for a hearing -- requested hearing.

16 And to date we've issued over 22,000 final
17 decisions out of the total of 39,000 -- almost 40,000
18 cases that we have received.

19 The breakdown, recommended decisions, you can
20 see almost 13 -- over 12,500 recommended decisions to
21 approve benefits; 19,000 to deny; final decisions,
22 almost 12,000 to approve benefits and 16,000 to deny.
23 Again, 16,000 -- that number is getting closer, Larry -
24 - 16,035 that -- referred to NIOSH. We've issued
25 payments in 10,619 and we're approaching \$800 million

1 in benefits and some -- over \$30 million in medical
2 benefits have been paid.

3 Initial decisions, again we've issued
4 recommended decisions in almost 32,000 claims or 24,000
5 cases. Again, there are 13,600 pending -- cases
6 pending at NIOSH and we've issued what we call our
7 initial decision in some 95 percent of the cases that
8 we've received since the program became effective on
9 July 31st, 2001.

10 Final decisions, final decisions in, again,
11 22,000 cases or almost 28,000 claims, and there are
12 final decisions issued in over -- in about 56 percent
13 of the cases received, you know, since the inception of
14 the program.

15 Again here's a breakdown to show -- that
16 shows the final decisions. Again, 11 -- almost 12,000
17 to approve benefits. Of the 16,000 to deny, as you can
18 see, some 9,000 -- almost 9,600 were denied because of
19 non-covered conditions; 25 -- 2,500 where employee was
20 not covered; 700 and some the survivor was not
21 eligible; and 2,200 was insufficient medical evidence
22 to demonstrate a covered condition. And this number is
23 going up, the -- now it's over 900 where the cancer was
24 not related or had a POC of less than 50 percent.

25 We track our -- we have -- do a lot of

1 internal measurement of our processes and our -- you
2 know, have standards for the performance. And under
3 the Government Performance Result Act, our standards
4 for initial processing is for a timely decision. In
5 this year we raised it from 75 percent to 77 percent,
6 and the two standards that we used -- if it's a DOE
7 facility or a RECA claim, within 120 days; 180 days if
8 it's an AWE or a subcontractor claim. And as you can
9 see, for this fiscal year we -- we did meet our GPRA
10 goals for last year.

11 For this fiscal year, which we made in -- of
12 the decisions that were made, the initial decisions
13 this fiscal year, 93 percent were completed in --
14 within those time frames and with an average of 92 days
15 to complete that initial decision from the time we
16 received the claim until the time the case is either
17 referred to NIOSH or a recommended decision issued.

18 On final decisions, it's -- again we have --
19 our standard is that we want a final decision within 75
20 days of either receipt of a waiver of objections or a
21 request for a review of the written record, and within
22 250 days if the individual requests a hearing. And
23 this fiscal year in the final decisions issued, 99
24 percent of the cases met the -- those standards.

25 Again, on -- we have a GPRA goal that --

1 processing time for the probability of causation, and
2 we have a average -- we hold our district offices to an
3 average of 21 days, from -- 21 days from the time a
4 dose reconstruction is received from NIOSH that they
5 have a recommended decision issued. And as you can
6 see, in the first quarter we met it within 99 percent
7 of the cases with an average of nine days. And the
8 second quarter this fiscal year, 97 percent with an
9 average of 13 days from the time of getting a
10 recommended decision to the claimant from the time we
11 receive the dose reconstruction back.

12 The status of the NIOSH referrals -- and
13 again, we've received 2,213 that -- with completed dose
14 reconstructions, 189 that they weren't com-- you know,
15 dose reconstruction was not necessary. And that could
16 be for various reasons. Most of them were early when
17 we had sent the CLL cases and, you know, when those
18 came back. Of those, the breakdown, the recommended
19 decisions, 528 to approve benefits and 1,388 to deny
20 benefits. Final decisions, 470 final decisions to pay
21 benefits and 691 to deny benefits.

22 Some Hanford-specific statistics. Again, the
23 nature -- we've -- this is -- we had an effort in the
24 last two months that -- with PACE to try to increase
25 the number of claims that we have received from the

1 Hanford site. That has been very successful. In the
2 last two months we've received over 275 new claims, of
3 which 200 -- yeah, the increase in the last two months
4 since -- since that outreach effort began, and now
5 we're up to 3,565 claims received from individuals
6 claiming Hanford as a work site. The breakdown, again,
7 most of them are cancer claims and 192 beryllium
8 sensitivity, 126 CBD and other non-covered conditions,
9 607. And again, that is way down, also. Most of those
10 were early -- early cases.

11 The breakdown, final decisions, 153 to
12 approve benefits, 557 to deny. Recommended, 160 and --
13 to approve, 785 to deny; 1,726 cases referred to NIOSH.
14 We've issued 70 payments and over \$9 million paid to
15 individuals at the Hanford work site. Just in the last
16 two months since our increased outreach efforts, we had
17 an additional 16 cases approved for benefits, 32 denied
18 in those two months, with 14 additional that have been
19 payments issued and 159 additional cases in that time
20 period referred to NIOSH.

21 And the nature -- again, 70 payments issued,
22 30 of them were for cancer, 40 for chronic beryllium
23 disease and we have 100 individuals that have been
24 awarded benefits for beryllium sensitivity and
25 receiving medical monitoring.

1 The status of the NIOSH referrals from
2 Hanford, 209 that we've received back, 205 with
3 completed dose reconstructions. Recommended decisions
4 in 28 cases to approve benefits, 138 to deny and 27
5 final decisions to approve benefits and 33 to deny.

6 Our outreach efforts, we've -- again, we've
7 tried to -- been trying to greatly enhance our outreach
8 efforts, and our goals are to identify potential
9 claimant populations, solicit claims from non-filers.
10 We've been tracking very closely and trying to look
11 into various sites, more specifics of the nature of the
12 claims. And where we're not getting the number of
13 claims that we expected, we've been collecting a lot of
14 facility information and to promote -- goal to promote
15 public knowledge and awareness of the program and to
16 provide assistance in filing claims, as necessary.

17 Our district office -- our district offices
18 have been charged with coordinating the outreach
19 efforts of the district offices, along with the
20 resource centers in each of those areas, and to
21 research employers at the covered facilities. And
22 we've been focusing on trying to increase stakeholder
23 involvement in our outreach efforts with unions, media
24 outlets, advocacy groups and health care providers.

25 We had a pilot program here with PACE that,

1 again, has been very successful and I want to thank
2 Randy Knowles again for -- for their efforts. It's
3 been very successful. And we've had meetings, you
4 know, with PACE here, public meetings. We've had a lot
5 of media outreach. We've met with a number of the
6 local law firms here. And based on that, our resource
7 center has had -- just in those two months -- an
8 additional 353 contacts have been made, people that
9 have come in for interviews.

10 Some of -- on a national scope, some partners
11 that we've been working with in our -- in our outreach
12 efforts, the Center to Protect Workers' Rights. We
13 have a -- an effort there where not only outreach, but
14 the Center to Protect Workers' Rights -- we've had a
15 difficult time, especially with some of the
16 subcontractors, and they've -- we've put together a
17 program and it's been very successful. They have
18 performed well beyond what is called for in the
19 contract and, as Knut liked to point out, under budget.
20 So that's been a real good effort where they've --
21 we've been able to get employment verification
22 completed on a number of very difficult cases that we
23 were having problems with that, you know, the records
24 just didn't exist. And we were able to -- they have
25 access to some record sources that have turned out to

1 be very useful in that. And then we're also working
2 with them to try to increase and develop some outreach
3 efforts -- one of the things we were just beginning
4 discussions on is a national effort for construction
5 workers -- national outreach effort to reach many of
6 the construction workers that worked at the different
7 sites.

8 We're in discussions with the National Cancer
9 Society and there's going to be links on their web site
10 to the program to identify, you know, potential sources
11 of -- that people may come to for assistance.

12 We also have an effort going on with the
13 Cancer Treatment Centers of America. This is an effort
14 where we're -- a number of thing-- we're cross-matching
15 -- we're going to give them a listing of employers at
16 the -- different sites that we have identified and
17 they'll cross-match on their records, and anyone who
18 may have listed that employer as an employer, then
19 they'll send a mailing -- a letter that we give them --
20 to that current patient or former patient notifying
21 them about the program and the elig-- you know,
22 potential eligibility for benefits. So that effort is
23 going on.

24 We have a strong effort with the California
25 Beryllium Vendors. We've had a number of meetings with

1 -- with those folks to try to make them aware of the
2 program. And in fact, one of our goals is to reach
3 beryllium vendors across the country, particularly very
4 -- we have gotten very little from subcontractors of
5 beryllium vendors.

6 And a -- we have a effort going on with the
7 National Councils of Laborers, and that's been very
8 promising. And we're also working with them on some of
9 their trust funds that -- in order to reimburse for
10 payment of medical benefits and also to identify
11 potential claimants there.

12 And we have an agreement with the Ohio Bureau
13 of Workers' Compensation. This effort that -- we've
14 had a number of joint claimants, particularly beryllium
15 claimants up in, you know, the Toledo area and we've
16 signed an agreement with the State of Ohio to do cross-
17 matches of claimants, so -- also we're -- we have a
18 process where we have reimbursed the State of Ohio for
19 medical benefits that they may have paid for a claimant
20 who then receives benefits under the DOL program. And
21 that's going very well. In addition, there's a lot of
22 exchange going on -- data exchange for -- particularly
23 subcontractors at various sites in the state of Ohio.

24 And just as a -- each of our districts --
25 we're in a process -- we've met with each of our

1 districts and -- along with the affected resource
2 centers and -- to come up with a strategic plan for the
3 next six months in our outreach. We have Jacksonville
4 to do. We've met with the other three districts so
5 far and we'll be meeting with Jacksonville I think it's
6 week after next to come up with their -- their plan.
7 Basically what that amounts to is our Cleveland
8 district office and the affected resource centers, the
9 -- for the next three to six months they're going to
10 focus on outreach to Fernald and Mound, with the
11 rationale there being that those two sites are closing,
12 and also the beryllium vendors. Again, we've -- the
13 number of claims from beryllium vendors has dropped off
14 considerably and they -- we haven't had a lot of claims
15 from subcontractors of beryllium vendors.

16 Denver is going to be focusing on Rocky Flats
17 and Los Alamos, and we're trying to do our outreach and
18 tie it in with when the site profiles are completed and
19 coordinate, you know, these efforts with -- with NIOSH
20 and the site profiles.

21 Seattle will be focusing here in -- at
22 Hanford and in California, and our Jacksonville office
23 -- right now, again, we'll be meeting with them to nail
24 down in a -- week after next, exactly what their
25 outreach is going to be.

1 Additionally, we have -- on a national basis
2 we're going to begin doing some what I refer to as
3 educational outreach. I think that we have not done a
4 very good job of educating people of the process so
5 that, you know, when we get these large numbers of
6 decisions coming back, it's -- I don't think we've done
7 a good job of explaining to people why two people that
8 may have worked together -- one, you know, goes through
9 a dose reconstruction, has a certain type of cancer, is
10 being compensated; the person they worked next to is
11 not. So we're -- we're trying to develop some
12 educational outreach efforts there.

13 The first one, we're scheduled -- we're
14 trying to schedule is to go up to the Buffalo area to
15 have such a meeting with the people from the --
16 particularly from the Bethlehem Steel facility there.

17 And with that, that -- open...

18 **DR. ZIEMER:** Thank you, Pete. I think you
19 were out of the room during our earlier review of our
20 minutes from our previous meeting, and then a question
21 arose in the reporting of some of your statistics in
22 our minutes. And I'm wondering if a similar confusion
23 might not arise again. If we look at slides, for
24 example, four and five of your presentation -- and I
25 know that the specifics that I'm going to ask about are

1 given in later slides, but I think what happens is that
2 as people look at these slides, they may get misled.

3 For example, a bullet on slide four says
4 cases sent to NIOSH for dose reconstruction, 16,035.
5 The very next bullet says payments issued, 10,619. The
6 casual reader may be tempted to assume that there have
7 been 10,619 NIOSH cases that have been issued payments,
8 so perhaps in the future we could clarify -- for
9 example, of the payments issued, what fraction of those
10 --

11 **MR. TURCIC:** Okay.

12 **DR. ZIEMER:** -- involve NIOSH. Similarly, in
13 the following slide, cases pending at NIOSH, 13,633;
14 initial process completed for 95 percent of the cases
15 received. I don't know if that 95 percent is of all of
16 Labor's cases or those NIOSH cases.

17 **MR. TURCIC:** Okay.

18 **DR. ZIEMER:** You understand?

19 **MR. TURCIC:** Okay.

20 **DR. ZIEMER:** So a little bit of
21 clarification, really --

22 **MR. TURCIC:** Yeah, we'll restructure --

23 **DR. ZIEMER:** -- in connecting those with your
24 later slides which are NIOSH-specific, which give the
25 actual numbers.

1 **MR. TURCIC:** Okay, we'll restructure that and
2 try to make it clearer.

3 **DR. ZIEMER:** Very good. Yes, Roy and then
4 Jim.

5 **DR. DEHART:** Roy DeHart. My question is, you
6 had mentioned that in the process -- the legal process
7 of going through, that there are hearings that have
8 been occurring. Could you expand on that a bit, the
9 justi-- not the justification, but the issue around
10 most of those hearings?

11 **MR. TURCIC:** What -- once a claimant gets a
12 recommended decision, one of their options is to file
13 objections. And they can raise objections and, if they
14 so choose, they can ask for a hearing. And then they -
15 - at the hearing they can present their objections and
16 to date -- we're starting to get a number of hearings
17 that are dealing with issues in the dose
18 reconstruction. Prior to that, most of the hearings
19 dealt with -- objections dealt with factual information
20 that -- or a lot of them dealt with, you know, non-
21 covered condition, why -- or why are you saying it's --
22 it's not covered. Now we're starting to get quite a
23 number of requests for hearings that are dealing with
24 the specifics on a dose reconstruction.

25 Now the way that works is that DOL will have

1 to adjudicate factual information that goes into the
2 dose reconstruction and the application of methodology.
3 So someone can raise an issue that the -- in the dose
4 reconstruction, either a factual piece of information
5 was not covered -- then we would have to address that
6 and either, you know, address it in the final decision
7 or remand it back to NIOSH for -- to redo the dose
8 reconstruction. Or they could also object to the
9 application of methodology, saying that it's not --
10 wasn't consistent with other cases or whatever, you
11 know, the objection may be.

12 So far, we've gotten objections that range
13 from that certain issues were not covered in the dose
14 reconstruction and what we would do is we then go back
15 to NIOSH and see how that was addressed, and then in
16 the final decision would either be to address it, you
17 know, at that point in time or remand. But we're --
18 we're also -- instituted -- and maybe at the next
19 meeting I'll have some hard, you know, data for you.
20 We've asked our hearing representatives to identify and
21 report issues that are coming up as, you know, that --
22 that -- when claimants request a hearing. You know,
23 what -- what are the issues particular -- you know,
24 relative to the dose reconstructions that are -- that
25 are being raised.

1 **DR. MELIUS:** Actually first question's along
2 those same lines and Jim Neton talked about -- I think
3 you call them remakes or --

4 **MR. TURCIC:** Reworks.

5 **DR. MELIUS:** Reworks, okay, whatever the --
6 and -- confuse me, but those are cases that have gone
7 up -- this has nothing to do with the hearings. These
8 are cases that have gone --

9 **MR. TURCIC:** Right.

10 **DR. MELIUS:** Could you talk -- explain a
11 little bit about the process --

12 **MR. TURCIC:** Sure.

13 **DR. MELIUS:** -- there and what kind of
14 issues...

15 **MR. TURCIC:** Sure. We found that in -- more
16 often than we expected, the situation may change. For
17 example, another cancer. The individual may have been
18 diagnosed with another cancer that was not addressed in
19 the dose reconstruction because they didn't have that
20 cancer diagnosed at the time the dose reconstruction
21 was done. So that case may have to go back to have
22 that cancer covered.

23 Another instance is that we -- we have
24 sometimes -- you know, our district office may not have
25 done a -- either a -- the form for the -- you know, for

1 skin cancer or smoking -- for lung cancer, and it may
2 have to go back. There may have been errors in the --
3 or changes in the ICD-9 codes. So there are --
4 there's, you know, a number of reasons why these
5 reworks have gone back. I don't think that to date --
6 and again, we are just in the process of getting the
7 requests for the hearings on dose reconstruction cases
8 in large numbers -- that we have remanded any on dose
9 reconstructions. I'm not aware of any that have been
10 remanded yet.

11 DR. MELIUS: One of the topics that Jim Neton
12 mentioned was the employment history discrepancies.

13 MR. TURCIC: Right.

14 DR. MELIUS: That was the one I was sort of
15 trying to figure out how that could occur, though it
16 seems to me -- I mean I know one of the issues has been
17 figuring out how the employment history matches up with
18 the exposure records.

19 MR. TURCIC: Uh-huh.

20 DR. MELIUS: So is it related to that or is
21 it related -- that you get new information or more
22 information about the person's --

23 MR. TURCIC: It could be both.

24 DR. MELIUS: Okay.

25 MR. TURCIC: It could be that we have gotten

1 more information. Sometimes we don't get that
2 information till after a final decision and the
3 individual asks for a reopening, and so we may get
4 information -- additional employment on a number of
5 cases. We -- we have the process set up because
6 oftentimes in -- in NIOSH getting the exposure records,
7 they find additional employment that was not -- was not
8 verified up front. Those -- they continue working it
9 and note it so that -- but then before the case can
10 become final, we may have to verify that employment.
11 You know, if that additional employment was found
12 through records, that's very easy to verify. But if
13 the additional employment was talked about in an
14 interview, we may have to go back and redevelop that,
15 so there -- there may be instances there that, you
16 know, we need to rework the case.

17 **DR. MELIUS:** Okay.

18 **DR. ZIEMER:** Wanda Munn.

19 **MS. MUNN:** Thank you very much for these good
20 statistics. Along the same vein that was discussed a
21 little earlier with respect to breaking numbers out,
22 I'm particularly pleased, obviously, to see the Hanford
23 site statistics. I'm doubly pleased to do so because
24 one of our nationally-elected officials was quoted
25 publicly here recently on a couple of occasions of

1 saying out of 35,000 cases -- claims, only one had ever
2 been paid. So I'm pleased that you have some more firm
3 numbers than that.

4 In the first Hanford site statistic,
5 compensation figures, we had the same kind of problem
6 that we previously mentioned --

7 **MR. TURCIC:** Yeah.

8 **MS. MUNN:** -- in that it is not clear to the
9 casual reader or even to me, as a matter of fact --

10 **MR. TURCIC:** Uh-huh.

11 **MS. MUNN:** -- how much of this compensation
12 is applicable to the concerns of this specific Board,
13 so --

14 **MR. TURCIC:** Okay, yeah, we'll do -- we'll
15 break that out specifically, yeah.

16 **MS. MUNN:** As a -- as a sub-note, if you
17 would break that out in the future.

18 **MR. TURCIC:** Okay.

19 **MS. MUNN:** Just so we know what our specific
20 cases --

21 **MR. TURCIC:** Okay.

22 **MS. MUNN:** -- are doing, we'd certainly
23 appreciate it. Thank you.

24 **MR. TURCIC:** Okay, no problem.

25 **DR. MELIUS:** Another question. We're going

1 to spend a lot of our time -- this Board -- tomorrow
2 dealing with setting up the individual dose, you know,
3 review process with our -- with our contractor and so
4 forth, and I was just wondering if you had any views on
5 how that process sort of ties into your efforts at the,
6 you know, Department of Labor and issues -- obviously
7 we're not, you know, reviewing individual cases per se
8 and -- but -- but issues may arise during that process
9 that may affect future claims or other claims and how
10 that gets done and I'm just curious how you view it in
11 terms of your overall process.

12 **MR. TURCIC:** I think it's -- it's very
13 important to our overall process, and we would like to
14 see it as early in the process as possible. You know,
15 it's a quality control function. I would much rather
16 have issues identified that can be addressed, you know,
17 early rather than waiting until -- you know, from a
18 particular site that we may have 2,000 final decisions
19 and then find out that we may have to reopen all 2,000
20 cases. So as early as possible would be, you know, our
21 -- of benefit to us. And you know, the Board's input
22 on things like that would be very useful when we get
23 into these hearings on, you know, specific issues
24 relative to the -- you know, the dose reconstruction.

25 **DR. ZIEMER:** Gen Roessler?

1 **DR. ROESSLER:** Wanda's comment, along with
2 Pete's discussion of outreach, has prompted me to bring
3 up something that's been on my mind for some time, and
4 it goes back to something John Till told us when he
5 spoke to us about outreach. It appears that Pete's
6 program is doing a real good outreach with potential
7 claimants. But it appears that there's a big
8 disconnect, either misinformation or lack of up-to-date
9 information, with others -- the Congressmen and the
10 public and the media, perhaps. And going back to what
11 John said, I wonder if -- I don't know if it's the
12 Board's responsibility or somewhere we should have
13 maybe a quarterly newsletter that's written that could
14 be handed out to interested people. That's just a
15 beginning thought on that.

16 Now I know NIOSH has the web site, which is
17 fantastic, but how many people out there -- other than
18 us, and maybe including us -- what percentage of people
19 really use the web site? And is it -- is there a
20 statement on there that's concise enough to really
21 convey the progress that it seems like is being made on
22 this project? It's just a thought that I think we need
23 to pursue a little bit further.

24 **DR. ZIEMER:** I don't know if those were
25 rhetorical questions or if you want the NIOSH staff to

1 answer, but certainly thought-provoking ideas.

2 Other comments or questions?

3 (No responses)

4 **DR. ZIEMER:** Pete, thank you again for --

5 **MR. TURCIC:** You're welcome.

6 **DR. ZIEMER:** -- updating us on the progress,
7 and NIOSH.

8 The Chair is going to declare a ten-minute
9 comfort break, even though it's not on your agenda.
10 But we will take ten minutes before our next speaker
11 comes to the podium. So please avail yourselves of the
12 ten minutes, but come back promptly.

13 (Whereupon, a recess was taken.)

14 **STATUS REPORT - DOE**

15 **DR. ZIEMER:** Okay, I'd like to call the
16 meeting back to order, please. Our next speaker will
17 be Tom Rollow with the Department of Energy, and Tom's
18 going to give us a status report and update on DOE's
19 path forward. Okay, Tom.

20 **MR. ROLLOW:** Good morning. Since I talked to
21 you folks last, I -- to this Board about -- in the fall
22 -- last fall, I think it was in St. Louis, we've made a
23 lot of progress. It's been real exciting. I think the
24 main messages I want to share with you today are that
25 we've put a maximum amount of our resources to work and

1 made some great progress in processing cases for the
2 Part D portion of the program. We have a new plan
3 which I'm going to share a little bit with you today on
4 how we get from here to eliminating the backlog over
5 the next two and a half years.

6 And just as a reminder to the audience -- I
7 know the Board is well aware of this -- Part D is the
8 part of the program administered by the Department of
9 Energy. It has to do with Workers Compensation and not
10 with a compensation payment from the Department of
11 Labor. And it's not necessarily under the auspices of
12 this Board, but is basically a sister program to the
13 program run by the Department of Labor and the National
14 Institute of Occupational Safety and Health.

15 I'd just like to start out here and say that
16 first -- as a reminder, the first bullet up there, DOE
17 provides determinations on causation by qualified
18 physicians on our applicants, and these are
19 determinations that affect the processing of the cases
20 to state workers compensation. The determinations --
21 as you're going to see in a later slide, but the
22 determinations that we've -- that we're now producing
23 on a weekly basis have increased, but not nearly enough
24 to reduce the backlog. Now we think it's a matter of
25 resources and some legislative changes and some rule

1 changes, and I'll touch upon those.

2 Our plan to eliminate the backlog will take
3 about two and a half years to achieve. That plan is a
4 combination of increasing our current production,
5 eliminating backlog. We need some Congressional help
6 to do that, both financially and legislatively.

7 Last bullet on this slide, DOE is maximizing
8 our applicants' opportunity for state workers
9 compensation benefits. Again, as a reminder, this
10 program helps people to apply for state work comp and
11 does not have a compensation payment associated with
12 it.

13 Just contrasting the two programs, Part D and
14 Part B, for everyone's information, the Part D program
15 administered by DOE is assistance with state workers
16 compensation, it's -- covers all illnesses related to
17 radiation and toxic exposure. If we look over on the
18 Part B side, the Department of Labor and NIOSH-run
19 programs have to do with radiation-induced cancers, and
20 in some cases beryllium and silicosis, as I'm sure
21 you're aware. And a large part of the radiation-
22 induced cancer determination is the dose
23 reconstructions performed by NIOSH.

24 Back on the left side of this screen, we use
25 physician panel determinations. NIOSH does enter into

1 the picture there because NIOSH helps us recruit and
2 actually selects and certifies the -- or qualifies the
3 physicians that serve on these panels for the
4 Department of Energy. Lastly, we gather radiation and
5 other medical and employment data at the sites.

6 We also do gather data for the Department of
7 Labor and NIOSH programs. In fact, Mr. Turcic -- who
8 was up here a few minutes ago -- talked about the
9 Department of Labor program. Almost without exception,
10 every case that has been acted on by the Department of
11 Labor and by NIOSH on that side of the program, we
12 collected the data and provided that to them for those
13 programs, both employment -- mostly employment data and
14 also the radiation data that -- that NIOSH uses.

15 This is a kind of a picture of where we are,
16 just to -- and for purposes of summary, our process can
17 be thought of as several different boxes in a time
18 continuum processing these cases. There's an
19 application made here, next step is for us to interview
20 and work with the applicant to figure out what the
21 illnesses they're claiming, where they worked. Then we
22 go get records from the site. Once we have the records
23 from the site, we put together a case, and once we put
24 together the case, it goes before the physicians panel.

25 This is a picture of the cases per week that

1 we've actually been processing and preparing cases for
2 the physicians panel. So these are not cases
3 completed, but these are cases prepared by the
4 Department of Energy for the physicians panel. On the
5 left-hand side here, these are cases processed per
6 week, and down on the bottom is a time line.

7 If you notice this dotted line right here,
8 this has to do with some financial changes that
9 occurred in our program last fall, but it also is about
10 the same time I think I came out to St. Louis and
11 talked to you folks, so at that time we were preparing
12 about -- looks like about 30 or 35 cases per week for
13 the physicians panels, the Department of Energy. Today
14 we're actually producing somewhat greater than 100
15 cases per week. We're averaging about 120 cases per
16 week for the physicians panels.

17 Let's see -- this chart -- as I was drawing
18 this diagram in the mid-air up here, this chart
19 represents the physician panel determinations, so it's
20 kind of the downstream end of the process. This is
21 after the physicians have actually finished reviewing
22 the cases and a determination has been sent back to the
23 applicant. And again you can see that in the early
24 part of the program we were averaging somewhere less
25 than five cases per week. And since middle or late

1 January, we've actually -- are averaging up around 30
2 cases per week processing for the physicians panel.

3 The reason that these changes have taken
4 place are -- there's several reasons for that. One of
5 the main reasons is we did start full-time physician
6 panels in Washington, D.C. The early concept in this
7 program when I first took it over about a year ago was
8 that we'd use part-time physicians. NIOSH would
9 appoint these physicians and we would put them together
10 part-time, working in the field, coordinating
11 electronically to rule on these cases. We have since
12 found that it's very efficient if we can get the
13 physicians to meet all in one place at one time. So in
14 early January we started bringing physicians to
15 Washington -- one, two or three weeks at a time -- and
16 putting them together in Washington and actually
17 serving on a panel where they can work together in one
18 room. And the productivity went up dramatically in our
19 program for doing that, and we're trying to get more
20 and more physicians interested in working that way.

21 Our plan to eliminate the backlog -- we have
22 about 23,000 cases -- applications for this program.
23 We've processed something over 1,000 -- I'll show you
24 the numbers later in my package. But our plan to
25 eliminate the backlog results from a four-month

1 comprehensive review which we finished about a month
2 ago and has these aspects to it.

3 As far as the regulations go, we have
4 actually issued a new rule about a month ago. It's out
5 for comment -- for 30 days comment right now, but we're
6 actually operating to it, and that new rule changes the
7 number of physicians on a panel from three physicians
8 to one physician. Now what that means is that one
9 physician will look at a package in an application and
10 rule on it. If that is in fact a positive, that
11 application package is done and that person gets a
12 positive determination. If that application is a
13 negative, then it would go on to a second and to a
14 third review to give the applicant the benefit of the
15 doubt to make sure that -- before we give them a
16 negative -- that two out of three physicians agree that
17 that was a negative physicians panel finding.

18 The legislation component -- components of
19 our plan involve changing the physicians' pay cap. As
20 you may or may not be aware, the original legislation
21 fixed the pay cap at a executive level three level,
22 which basically comes out to be \$68 an hour, and we've
23 found that physicians doing this kind of work typically
24 see two -- a factor of two or more times that pay per -
25 - on a per-hour basis, and that is affecting our

1 ability to hire and attract physicians to work in this
2 area.

3 Also we are looking for legislative changes
4 to expand the hiring authority. Basically the --
5 there's some restrictions in the current statute --
6 when I say statute, I mean law -- in the current
7 statute or law that restrict the physicians that NIOSH
8 can nominate for this program, and so we're looking for
9 some changes to the statute to expand that hiring
10 authority.

11 And then also there's a requirement in there
12 for a state memorandum of understanding with each state
13 before we can process cases in each state. And that's
14 really kind of a legacy or an antiquity for the
15 program. At one time it was thought that this program
16 might actually rule on each individual case on behalf
17 of the state, and at that time you'd obviously have to
18 have some kind of agreement with the state to spend
19 their money -- their work comp money or make their work
20 comp decisions for them.

21 The current program does not do that. The
22 current program provides a positive physicians panel
23 finding and then helps the employee make an application
24 for state work compensation.

25 Those legislative fixes have been recommended

1 to the Congress and we're looking forward to their
2 action on those legislative changes sometime in the
3 next few or many months.

4 As far as budget goes, year -- in FY 2004
5 currently we have a \$33 million appropriations
6 transfer. I'll talk a little bit more about that in
7 another slide, but we've asked Congress to allow the
8 Department to move money from other tasks inside the
9 Department to this task, and that request has been in
10 to the Congress since about January and we're hoping to
11 get action on that soon. That will allow us to apply
12 more resources and process more cases, which I'll show
13 you in just a minute.

14 In the year 2005 or FY 2005 we have a healthy
15 budget, \$43 million budget request in. And when I say
16 healthy, as I've shared with you last fall in St.
17 Louis, we under-estimated the level of applications in
18 this program early on and got a slow start, and these
19 are monies that will help us catch up in the
20 processing.

21 Lastly, we've also implemented or are in the
22 process of implementing many process changes. We've
23 increased physicians recruiting, working closely with
24 NIOSH to try to get more physicians attracted to
25 working in this program. The physicians panels are our

1 major bottleneck in this program, and that cannot be
2 solved just by resources. We've got to find qualified
3 physicians to process the cases.

4 We're also going to put together a tiger
5 team. The Department of Labor has agreed to work with
6 the Department of Energy to put together a tiger team,
7 and those of you that -- been around DOE sites for
8 ten-plus years -- no, this is not that kind of tiger
9 team. But put together a tiger team to help categorize
10 and rate suggestions that have been made to date for
11 this program and figure out which ones will give us the
12 best bang for our buck and implement those kinds of
13 changes. I'll touch on that in another slide here in a
14 few minutes.

15 Also we are prioritizing cases -- living
16 applicants before deceased applicants, for example. We
17 try to process those first because those may have
18 medical benefits which can benefit people sooner. Some
19 of the cases involve dose reconstructions that NIOSH is
20 performing. Previously we could have sent those to
21 panel without a dose reconstruction and then waited
22 some number of months or a year later to get the NIOSH
23 dose reconstruction. It might have conflicted with the
24 ruling of the panel, so we're going to hold back on
25 those cases and await dose reconstruction before we

1 send those to panel. That provides both consistency in
2 the panel findings, as well as allowing some of our
3 other cases to go forward while we're waiting for the
4 dose reconstructions.

5 The supply of physicians, as I mentioned, is
6 our number one challenge or number one bottleneck in
7 this program, and I've touched on these issues before -
8 - the inadequate compensation issue which is outlined
9 there. Limited hiring authority is more of a
10 bureaucratic challenge, but if you're interested,
11 basically the law or the statute that we're allowed to
12 hire physicians under kind of characterizes them as
13 part-time workers, yet this is a two and a half year
14 program to reduce the backlog, and we need physicians
15 that can work hard, hot and heavy for us full time for
16 two and a half years or more, so we need some changes
17 in the statute to allow us to do that. I don't think
18 there's much more to say on that particular slide.

19 This is an interesting slide. I'll take a
20 minute and explain some of the aspects of it so you can
21 kind of focus on it. On the left-hand side is full
22 time equivalent hours. And full time equivalent hours,
23 for those of you not familiar with the term FTE, if
24 someone is working one hour a week for you and a full
25 time person works 40 hours a week, then you get one-

1 fortieth full time equivalent. Okay? So that's
2 actually a pretty good explanation on how this chart
3 lays out.

4 If you see this -- the dark blue up here, it
5 says 167. NIOSH has appointed for the Department of
6 Energy program to day -- when I say to date, this was
7 like a month ago because NIOSH actually sent us 40 more
8 physicians in the past few weeks. But NIOSH has
9 actually appointed 167 physicians to our program here.
10 Of those 167, 129 are currently working actively in the
11 program. And the difference between those two numbers
12 is just basically some docs are on vacation or for
13 whatever reason -- they got appointed to the program
14 but they don't have time to work on the program, so
15 basically we have about 129 docs that work full time.

16 But 129, we don't get 129 FTE from them.
17 They originally committed to NIOSH that they would work
18 for about 16 hours per month. If they worked for 16
19 hours per month, you'd get this many FTE -- I guess
20 that looks like it's about eight or nine, ten FTE there
21 in that brown bar. What we're actually getting from
22 them right now on average is about four hours per
23 month, so just a couple FTE down here in this purple.

24 Where we need to go to accomplish our plan
25 and to process these cases is we need 20 FTE by June of

1 2004, goes to 35 FTE in January of 2005, and we need 60
2 FTE in April, 2005 and then to the end of calendar year
3 2006 to make this program work. So that kind of gives
4 you a picture of where we need to go. And this is --
5 these are big steps. These are giant leaps to get from
6 this little purple bar here to those yellow bars, and
7 it's going to take a lot of work on our part and on
8 NIOSH's part to identify and put to work those
9 physicians.

10 Physician productivity issues, there were
11 stumbling blocks or some challenges, some obstacles in
12 the statute and in the DOE rule that was originally
13 produced. I've touched on this before. The rule
14 required three physicians. We're going to one. That
15 we have seen near-unanimity of results from these
16 panels. It's taken us two to four weeks to coordinate
17 these three-physician panels by telephone and e-mail,
18 and we think going to a single physician will give us
19 some great efficiencies there, also.

20 I talked about dose reconstructions, there
21 was a possibility of double determinations or
22 conflicting determinations with dose reconstructions.
23 If we sent through a case today and then got a NIOSH
24 dose reconstruction that disagreed with that case a
25 year from now, that would have presented some

1 challenges for the program as to how to deal with that.
2 Also it's much more efficient for our physicians panels
3 to deal with a dose reconstruction if it's already
4 performed. They can just look at it. In fact, there
5 may even be a possibility -- we talk about it down here
6 in the lower right-hand corner -- of some presumptive
7 determinations and not even have to go to the panel.
8 Say if we had a positive dose reconstruction for a
9 certain cancer from NIOSH, why even send it to the
10 panel; just give it some kind of blanket approval and
11 move it on. So those are some of the things that we're
12 studying.

13 There's not much more I want to say on this
14 slide. Let me move on to the next one.

15 Physician panel rule, I've touched on --
16 provides a doubling of cases per physician. We
17 calculate or we estimate that we'll get about a double
18 -- a factor of two increase in our productivity going
19 to a single physician's panel. Now you say well, gee,
20 Tom, if it's one physician versus three, you ought to
21 be three times faster. But it actually doesn't work
22 out that way because there are negatives, and the
23 negatives have to go to a second and a third physician.
24 And if you take the number of -- the percentage of
25 negatives that we have versus the percentages of

1 positives and you do some simple math, you wouldn't see
2 a doubling, you'd see a different number. But we also
3 think that there's more efficiencies, as I mentioned
4 before, by a single physician working alone than having
5 to coordinate with two or three -- with two other
6 physicians electronically and e-mail. So we think that
7 the -- actually going to -- change the number of
8 physicians should give us a reduction in physician
9 hours per application by about 58 percent.

10 Also it will save us money. We calculated
11 \$37 million in physician panel pay because there'll be
12 less physician hours spent on these determinations. On
13 the flip side, we plan to put that same \$37 million
14 back to work again both in increased pay for physicians
15 -- if we can get that legislation through the Congress
16 -- as well as faster rate of production. So we're
17 going to spend that money, so I don't want anybody in
18 the room to think we can turn that back to the
19 Treasury. We need to put that money back to work.

20 The case development process, when I was
21 drawing this diagram in thin air up here --
22 application, case development, physicians panel,
23 notification to the employee -- case development
24 process is a little bit back upstream. That process
25 we're actually pretty comfortable with today with the

1 resources that we have available. We have pretty much
2 tweaked and optimized that process, and I'll show you
3 some numbers here in a few minutes.

4 Some of the issues that we have as far as
5 ramping up, when the funds are available, to processing
6 sufficient cases to work off the backlog in two and a
7 half years, number one, not enough case managers, but
8 that's simply a resource issue. We know where the case
9 managers are. We know how to hire them. We use
10 contractors for this work and so they're very -- it's
11 very quick to get them on board and trained up.

12 Additional productivity improvement still
13 available, we're going to bring in DOL/DOE tiger team
14 to help us categorize -- we've gotten a lot of
15 suggestions from different organizations that have
16 looked at our program. I brought in an independent
17 review from a company called the Hayes Companies last
18 August/September time frame. I also did an internal
19 self-assessment of the program. We identified
20 potential improvements from those activities. The
21 General Accounting Office, the GAO, has also made
22 suggestions. Government Accountability Project has
23 made some suggestions. And so this DOL/DOE tiger team
24 will take all those suggestions, prioritize it, figure
25 out the cost benefit, the return on the investment, and

1 implement the ones that make sense to implement.

2 Process is not standard throughout the field.
3 We are -- this program has actually benefitted, it's
4 actually been blessed, if you will, by having a lot of
5 records available in the DOE system. Some of that's
6 due to security. Stuff got classified in the past and
7 stayed classified for many years and it made it harder
8 to destroy. In the other cases, DOE -- the DOE program
9 is just a pack rat and it has retained a lot of
10 records.

11 In other cases, there are regulations for
12 retaining records. For example, radiation exposure
13 records have to be maintained for 75 years. So we're
14 lucky that those records do exist. Because they exist
15 in many different shapes and forms at different sites,
16 the collection of those records, both to support NIOSH
17 dose reconstructions as well as to support the
18 Department of Energy's work, it looks a little bit
19 different at each site as far as how those records are
20 collected.

21 Over the years the records were treated
22 differently at different sites. Some of them have been
23 made electronic, digitized. Others are still stored in
24 boxes. Some of them have people's names on them. Some
25 of them had employee -- you know, employee numbers on

1 them, so you have to go correlate those to the people's
2 names and Social Security numbers. So it's been a real
3 challenge all around the complex of putting these
4 records together. There's probably some optimization
5 we can do through some standardization of collecting
6 those records, and we'll continue to work on that.

7 Additional operational improvements and
8 reprioritization of cases, I touched upon this a little
9 bit earlier. We have -- we allowed our advisory
10 committee -- our board, not unlike you, to expire last
11 January, and we are in the process of reauthorizing our
12 advisory board -- our new advisory board. This board
13 will be focused more on the production end of the
14 business and less on the conceptualization of the
15 program end of the business. But we expect the first
16 meeting -- we expect those members to be appointed
17 sometime in the next three or four weeks, and we expect
18 to have our first meeting -- we hope in the month of
19 May.

20 I talked about applications as far as
21 prioritizing living applicants who are eligible for
22 medical benefits. Some applications also -- the
23 applicants will -- may never be avail-- eligible for
24 workers compensation benefits, like survivors who were
25 -- had reached the age of majority before their parent

1 passed away, and so those kind of applications may also
2 be reprioritized to the back of the line so that we can
3 get the more needy cases or the more compensable cases
4 moving forward in the process faster.

5 This is another picture representing the
6 overall plan, if you will, the scope of the program.
7 And so let me just take a minute to kind of explain
8 this to you, kind of let our eyes study it here for a
9 minute. On the left-hand side is cumulative cases
10 processed, and I mentioned the word -- the number
11 23,000. We have about 23,000 cases -- applications
12 today, yet this -- this chart goes up to September '07
13 and has numbers up above 30,000 on it. We're still
14 getting applications in at about 100 to 150 a week for
15 this part of the program, and so whatever plan we have
16 over the next three or four years working off this
17 backlog has to take that into account, those cases
18 still coming in.

19 The green line here is cases processed for
20 the physicians panels. So this is mostly my people
21 working with the sites to get the records and put
22 together the cases. And if you look on this chart,
23 we're somewhere right here before this point of
24 inflection in the chart waiting for additional
25 resources for Congress to let us move that money from

1 one part of DOE to the other, and then we can put the
2 case production past this point of inflection and put
3 it in this -- this increase right here and process
4 cases -- about 300-plus cases per week going up that
5 green line.

6 The dotted blue line is the physicians panel
7 process, which is much harder for us to manage, and
8 it's not just a resource issue, but it's find
9 physicians and work -- work smart in the physicians
10 area so the physicians panels can process over 300
11 cases per week. And we anticipate that that increase
12 is going to lag the green line by some number of months
13 as we make these changes and get up to speed. For
14 example, I made the rule happen a month ago. I can't
15 make the legislation happen. That's the Congress's
16 job. And so we have the proposal over on the Hill, but
17 it could be well into the summer or the early fall
18 before statute changes take place that can help this
19 program.

20 This is just another picture of the plan,
21 looking at it strictly from determinations per week of
22 physicians panel. And so the left-hand side here is
23 determinations per week. As I mentioned before, we're
24 somewhere down around 30 or less than 30, so we're --
25 that's the solid line -- and this is our plan over the

1 next 12 months. If you recall when I was showing you
2 that chart of FTE, how that stair stepped up over the -
3 - over a 12-month period getting more and more
4 physicians FTE time, that's what this sloping line
5 reflects. At some point we hope to be processing
6 physician panel determinations greater than 300 per
7 week, and that will allow us to work off the backlog by
8 the end of calendar year '06. And when we hit that
9 point in calendar year '06 working off the backlog,
10 then we're basically working in steady-state time, so
11 that's why you see a dramatic drop-off in physicians
12 panel determinations because we don't need as many
13 physicians at that point in time.

14 Again, as I've emphasized to you in my
15 presentation today, budget and legislation. We have
16 worked hard on optimization up to this point. We think
17 we've done a good job in maximizing the use of the
18 current funds to do -- and the current physicians that
19 we have to process as many cases as rapidly as we can.
20 To move forward from here forward, we need budget and
21 legislation, and I think I've touched on that
22 adequately.

23 These are the numbers -- and I can come back
24 to the Hanford numbers. I think what I'd like to do is
25 go past Hanford and PNNL and just talk about the

1 national program statistics here for just -- just a
2 minute. We can come back and talk about Hanford -- I
3 don't want to shortchange Hanford and PNNL, but we can
4 come back and talk to them here in a minute.

5 We have 23,000 applications to the program,
6 23,600. A couple of things to observe on this chart
7 here. Of those 23,000, we are done, complete, with
8 2,140. Now we get -- we get complete in several
9 different ways. Like Labor, we have applications that
10 are ineligible. They applied for a disease that's not
11 covered by the program, they applied for a facility
12 that's not covered by the program, or they applied
13 during a time period that's not covered by the program.
14 And a large majority -- or a significant percentage of
15 Labor's rejections are also in the -- in the same
16 category. This also includes, though, physicians panel
17 determinations -- looks like about 400 to 500, both
18 positive and negative determinations. And then there
19 are some situations where people withdraw -- withdrew
20 their case for one reason or another. So we've
21 finished 2,140 cases.

22 Now just to kind of focus on this for a
23 minute, cases awaiting development, 9,600. So what --
24 what that says to us is we have some 12,000 -- 14,000
25 cases that we're currently working on, so we are

1 working 14,000 cases. If you were to look at this
2 chart over time, over the last six months, that number
3 was up in the high teens just four or five months ago.
4 We have significantly increased the number of cases
5 that are actually being physically worked.

6 If you do a little mental math here and you
7 take these 2,000 cases here that have been completed,
8 you take these 1,500 that are in the physicians panel
9 process today, and you take these 1,500 that were done
10 with that are waiting to go into the physicians
11 process, these -- these are the total cases that my
12 people have put together in Washington -- assembled for
13 these physicians panels -- and that says two, three,
14 four, five -- about 5,000 of the 23,000 cases DOE is
15 done with their work. DOE has finished their work on
16 those cases. All they're waiting for now is the
17 physicians panel, and so we need to solve that problem
18 so we can move those cases forward. But that reflects
19 a great leap in production since I think I talked to
20 you last fall in St. Louis.

21 With that, I guess I'll ask if you have any
22 questions that I can answer for you?

23 **DR. ZIEMER:** Thank you, Tom. Let's see, who
24 has questions? Okay, Roy.

25 **DR. DEHART:** Thank you, Tom, for the update.

1 I think the -- we all appreciate the new information.
2 Particularly I was delighted to see that there's a
3 reduction in potential conflict between Subpart B and
4 Subpart D with regard to requirements now of having
5 some kind of case reconstruction before you make a
6 decision on the worker comp side of the house.

7 On the advisory board, if I'm not mistaken,
8 you're asking for those participants to be volunteers,
9 not to be reimbursed. Right?

10 **MR. ROLLOW:** That is correct.

11 **DR. DEHART:** I don't understand why you would
12 do that when you're -- you're having problems moving
13 forward, but this Board is not all volunteer, I might
14 add.

15 **MR. ROLLOW:** That's information I didn't
16 know. I'll take that back to Washington.

17 **DR. DEHART:** You may find it helpful.

18 **MR. ROLLOW:** Okay. Thank you.

19 **DR. DEHART:** One other thing. In talking
20 with physicians, and I think you're aware that I've
21 been actively trying to recruit the program, one of the
22 common questions is the insurance issue. Members of
23 this Board may not realize that malpractice insurance
24 is not covered under this. We are not practicing
25 medicine in reviewing those records. It's an

1 omission/commission administrative insurance, and also
2 many of the doctors are hired physicians by
3 universities, by corporations, by whoever they happen
4 to work with and for, and their insurance wouldn't
5 cover them if they're doing this on their own time.
6 And what is the status of that consideration?

7 **MR. ROLLOW:** That insurance is in place, and
8 the fact that you're one of our practicing physicians
9 and you didn't know that tells me I have a
10 communications problem that I'll take back to
11 Washington and work on.

12 **DR. DEHART:** It's been about two months since
13 I've done a case, so that may be why, but thank you
14 anyway.

15 **MR. ROLLOW:** Yes, sir.

16 **DR. ZIEMER:** Jim, then Tony.

17 **DR. MELIUS:** Hoping that Larry will assure us
18 that this advisory panel is not going to expire -- had
19 us a little bit concerned there for a second, Tom.

20 I just wanted like first to clarify for the
21 record one issue, I think it was the reference to what
22 Wanda said during the previous -- when Department of
23 Labor was presenting. The quote -- the data from
24 Senator Cantwell was in reference to this program,
25 Subpart D, and refers to -- I think at least as of a

1 few weeks ago, one person had gone through the entire
2 program and got to the point of compensation. Now
3 there's issues, not to belabor them, of what the intent
4 of this program is and so forth, but that is an
5 accurate -- accurate figure that Senator Cantwell was
6 saying and it was something that Department of Energy,
7 you know, testified about a few weeks ago -- at least
8 former staff people at the Department of Energy -- do
9 that.

10 One of the question I had is -- relates to
11 some of your appropriations issues that you mentioned
12 about cutting back staff and -- and so forth if you
13 don't get the reprogramming. Are these staff at all
14 involved in activities related to this program?

15 **MR. ROLLOW:** In my slides there may have been
16 a couple of words that I didn't talk about today which
17 talk about making some cut-backs later in the year if
18 we don't see the appropriations. Is that what you're--

19 **DR. MELIUS:** Yeah.

20 **MR. ROLLOW:** -- talking about?

21 **DR. MELIUS:** Yeah.

22 **MR. ROLLOW:** Yes, those would be staff that
23 work for us through the M&O contractors at the DOE
24 sites that collect records.

25 **DR. MELIUS:** Uh-huh.

1 **MR. ROLLOW:** In other words, we're -- in the
2 records collection area we're working at a rate that
3 exceeds a level budget, if you will, in anticipation of
4 seeing this \$33 million reappropriation. If we don't
5 see it, we'll have to start laying off staff in the
6 next few months at sites.

7 **DR. MELIUS:** So that would mean that the
8 records coming to NIOSH would be cut back also?

9 **MR. ROLLOW:** That's a good question. We have
10 from day one, since I took over this program about a
11 year ago, I made the decision to put my customers
12 first, which was NIOSH and Department of Labor, and we
13 have never wavered in that -- on that commitment. And
14 there are many reasons for that, but one was that their
15 program was more mature and moving faster than ours was
16 and so right now my intentions would be to continue
17 that commitment and to put NIOSH and Department of
18 Labor information requests first. But as I start to
19 run out of resources, anything can happen.

20 **DR. ZIEMER:** Tony?

21 **MR. ROLLOW:** Let me, if I could, also, just
22 to add the -- the statement of one person has received
23 compensation. Let me just clarify that if I could for
24 the Board. We actually see that as light at the end of
25 the tunnel, as a great -- great achievement. The first

1 person at the end of our program has received
2 compensation from the state workers compensation
3 program. When people say well, gee, you spent -- and
4 they quote \$70-something million, it's really more in
5 the \$50 million in setting up this program, and you try
6 to divide that by a denominator of one, then it says
7 okay, \$50 million to get, you know, one case \$15,000.
8 That's not what actually has happened. What I just
9 showed you here is that -- I can't make this thing go
10 backward; there we go -- what I just showed you here
11 was that as far as the numbers go, there's a lot of
12 activity that's happening in the process. And not the
13 least of which is that 14,000 cases are being worked on
14 right now. So when you look at numerators and
15 denominators, you need to divide by 14,000 or some much
16 larger number than just one number in state workers
17 comp.

18 We also expect many of these positives --
19 right now our positives are standing at 163. One can
20 forecast that within the next four, five or six months
21 those positives might reach 1,000. And we expect many
22 of those to also result in financial compensation.

23 Now let me also be clear. We don't control
24 the financial compensation. That is controlled by
25 state process; it's different in every state. The

1 Secretary puts us in a position for maximizing the
2 probability of that compensation by ordering current
3 contractors not to contest a claim. But the states and
4 state laws actually govern that.

5 **DR. ZIEMER:** I think, Tony, you're next and
6 then Leon.

7 **DR. ANDRADE:** Right. Perhaps I missed it
8 during the course of your presentation, but during a
9 change in -- a reprogramming action, the money has to
10 come from somewhere. Did you mention where that
11 somewhere was, what it was, and given whatever its
12 origin may be, what your own personal assessment is
13 that the reprogramming is likely?

14 **MR. ROLLOW:** Let me make just a couple of
15 points on that. First of all, as far as the sources
16 go, I'm the guy running the workers comp program and
17 I've not spent a lot of time worrying about or studying
18 where it comes from. Now holistically, I do represent
19 the Department of Energy, and the Department of Energy
20 of course is very much aware and concerned of that.
21 And also our friends on the Hill in Congress look very
22 close at that also because there are many projects in
23 the Department of Energy besides the workers comp
24 arena, and many, many more considerations need to go
25 into those decisions as to where and when you move

1 money.

2 From my standpoint, though, I do believe that
3 the sources that were identified, a large part of them
4 were like construction projects where the money was not
5 used and now just needs Congressional approval to go
6 use let's say excess or leftover money from an earlier
7 project, use them in this project. In a couple of
8 cases it may represent projects that will not get
9 moving as fast this year as they -- as some may --
10 would like and therefore the Department says well,
11 let's use this year's money from that project on Mr.
12 Rollow's project and -- but I do think there's a high
13 probability that the -- that our friends in Congress
14 will agree that the sources, compared to the use of
15 this money for this program, would be acceptable to
16 them. So I do not expect that to be a stumbling block.

17 **DR. ZIEMER:** Okay, thank you. Leon?

18 **MR. OWENS:** Mr. Rollow, I've had several
19 occasions to meet with you, talk with you, and I guess
20 programs are measured in terms of success. And in
21 regard to Subpart B and Subpart D, I guess we would
22 measure them based on actual cases and claims that were
23 paid for the individual workers and/or the survivors.
24 And as I listened to your presentation, I think we know
25 that there is one glaring deficiency at a lot of the

1 sites in regard to a willing payer. And after reading
2 the Hayes report and reading the report by the Office
3 of Management and Budget, I think both of those point
4 to that as a deficiency.

5 I'm also aware under the former leadership at
6 the Department there was not as much interest in
7 addressing the willing payer issue. I know
8 specifically at my plant, Paducah Gaseous Diffusion
9 Plant, for those workers who do not have a covered
10 cancer, do not fall under Subpart B, there is basically
11 no one there, even if they receive a positive
12 physicians panel finding.

13 As part of the overall programmatic changes
14 that have been made, has the Department considered a
15 legislative fix to the willing payer issue coming from
16 the Department -- not just from the standpoint of
17 processing these claims and then getting an individual
18 to the point where they have a piece of paper that is
19 of no value?

20 **MR. ROLLOW:** That's a good question. Let me
21 talk globally about the program at large and then I'll
22 just touch upon Paducah here before we finish. The
23 willing payer question, just to frame that up for
24 everybody's information, is a term that was coined to
25 describe a situation where if the Department -- the

1 physicians panels give a positive finding to an
2 individual, to an applicant, and that applicant applied
3 for state workers comp, a willing payer situation would
4 be where the Department actually controls the
5 contractor, has a contract with the contractor where we
6 can tell that contractor when -- when Mr. Jones
7 applies, do not contest his claim. And that would be
8 to put the Department in the position of being a
9 willing payer, if you will.

10 There might be many payers for a claim --
11 insurance, state funds, other contractors -- that we
12 don't control might pay. Willing or not, they might
13 pay. But this situation is just the willing payer
14 question that Mr. Owens is asking about.

15 There've been several estimates that have
16 been put forth as far as what percentage of our
17 applicants might have willing payers, and those
18 percentages have varied from as high as 86 percent to
19 as low as 50 percent. And so I think, Mr. Owens, your
20 concern is that there's a -- that there's a group of
21 people out there that may get a positive physicians
22 panel finding that says yes, DOE harmed you, and they
23 may not be able to get any compensation for that
24 because of the willing payer issue.

25 The question is, what is the Department doing

1 about that. We are -- we are developing cases and
2 moving cases forward to see how the cases react, if you
3 will, in the state workers comp programs in each state.
4 And we're also doing some work studying the contracts
5 and insurance arrangements for all the contracts for
6 the Department of Energy. That work'll take me a
7 couple of months to do and that'll give me some good
8 indication of where I can and cannot make orders to
9 contractors to do not contest a claim.

10 As far as what's the final answer, is it 86
11 percent, is it 50 percent, we won't know that until we
12 have more cases under our belt. The official position
13 of the Department is that we will -- we're going to
14 contract, we're going to the National Academies to go
15 study this issue because it's not just a mechanical
16 question of how many cases are covered. It's also a
17 social question and it's a Congressional kind of legal
18 -- legislative kind of question.

19 Congress passed a law that said use the state
20 work comp system. The state work comp system in our
21 country does not answer that kind of willing payer
22 question. It's different -- it's different in every
23 state and in different situations. And there's a lot
24 of debate that went on on the Hill and we studied this
25 debate, and it's -- and it's -- we have to let -- we

1 have to let the law -- the law has to have meaning, and
2 so we have to -- we have to abide by the law. That's
3 what we're doing now.

4 So the answer to your question is we will not
5 be coming forth with any legislative fixes to the
6 willing payer problem this summer because we don't know
7 if it is a problem. We need to characterize that
8 through the summer, through the fall. Probably will
9 take maybe upwards of about 12 months to finish the
10 National Academy study and have more experience under
11 our belt.

12 Paducah, this will be good news for you, I
13 think. I guess I'm concerned you hadn't heard this
14 before, but as far as Paducah goes, all cases for
15 Paducah that -- for exposures that occurred prior to
16 July of 1998 when the Paducah plant was turned over to
17 USEC would be covered by Bechtel-Jacobs. In other
18 words, DOE would issue an order to Bechtel-Jacobs
19 Company not to contest.

20 **DR. ZIEMER:** Okay, Larry has a comment and
21 then -- or Leon, go ahead and follow up.

22 **MR. OWENS:** I guess my concern there, Mr.
23 Rollow, would be that it's just not positive if
24 Bechtel-Jacobs is going to continue to be on the site.
25 And so at the Congressional hearing that was held by

1 Senator Bunning, Bechtel-Jacobs at that point in time
2 stated that they had not been asked to be a willing
3 payer, had no knowledge of that. So I guess -- you
4 know, we're recompeting two contracts right now, and
5 Bechtel's basically not going to be in position next
6 fiscal year, so I -- you know, I'm struggling just a
7 little bit in the event that they're not even on-site.
8 I can't see them agreeing to serve as a payer, but...

9 **MR. ROLLOW:** Today, as you mentioned,
10 Bechtel-Jacobs is a willing payer and will be until
11 those contracts are placed for the Paducah and
12 Portsmouth sites, and at that time I -- prior to that
13 time it's the Department's intent that Bechtel-Jacobs
14 would be ordered through the contracting officer at Oak
15 Ridge to continue that responsibility. But that --
16 that legal document has not been written yet, so you're
17 correct -- you can't count on it until it's done.

18 **DR. ZIEMER:** Larry Elliott.

19 **MR. ELLIOTT:** Tom, you mentioned your intent
20 to establish an advisory committee. I assume and I
21 think I'm pretty right here, that's going to be a
22 Federal Advisory Committee Act chartered committee?

23 **MR. ROLLOW:** Right.

24 **MR. ELLIOTT:** What perspective of -- balance
25 of perspective do you hope to bring in that committee,

1 and how large or how small do you see it being?

2 **MR. ROLLOW:** Well, the committee, as -- in
3 the notice in *Federal Register*, I think it was in early
4 January, was described I think as having representation
5 from -- from labor, from -- I don't know the exact
6 terms, but the insurance company, the DOE contractors,
7 the DOE employees -- in other words, it could be both
8 labor or it could be employee representatives -- people
9 in the work comp industry -- I forget the exact -- the
10 exact cross-section, and we expect it to have about 12
11 members. And we have already solicited and gotten a
12 lot of recommendations into the Department of Energy,
13 and the Secretary is in the process of making that
14 decision to actually select the members, and then we'll
15 send that over to the White House for the White House's
16 endorsement. And so we expect to see that in three or
17 four weeks.

18 **DR. ZIEMER:** Thank you. Any other comments?

19 (No responses)

20 **DR. ZIEMER:** Again, thank you, Tom. We
21 appreciate the input and updating us on the DOE
22 program.

23 It's now time for our lunch break. We're a
24 little bit behind the agenda, but we have some sort of
25 flexible time at the other end, so we'll go ahead and

1 take our hour-and-a-half lunch break and reconvene at
2 1:30.

3 (Whereupon, a luncheon recess was taken.)

4 **DR. ZIEMER:** Let the record show that Mark
5 Griffon has arrived back from the Boston Marathon and
6 he did finish the race, and that's great -- good job.

7 (Applause)

8 **DR. ZIEMER:** He's keeping the time a secret,
9 so all I'll say is he finished the race, which is an
10 accomplishment in itself.

11 **DR. MELIUS:** Finished it in time to catch his
12 plane to get here.

13 **SITE PROFILE STATUS,**

14 **USE IN DOSE RECONSTRUCTIONS, AND ROLL-OUT**

15 **DR. ZIEMER:** We're going to now return to the
16 regular agenda, and we begin our afternoon session with
17 report on site profile status, and Jim Neton is back on
18 the roster. Jim?

19 **DR. NETON:** Thank you again, Dr. Ziemer. Had
20 a nice lunch, I hope everyone can stay awake through
21 this one. It's always tough addressing a crowd after a
22 long lunch hour.

23 I'm here to talk this time about DOE site
24 profile status, where we are, a little bit of an update
25 on what we've accomplished since the last Board meeting

1 two months ago. This is a companion piece to an AWE
2 profile discussion that I'm going to -- I'm scheduled
3 to present tomorrow -- I think morning sometime -- so
4 if you'll hold your questions on AWEs till tomorrow,
5 I'd appreciate it.

6 The first thing I'd just like to start with
7 is the basic definition that we've put in our site
8 profile web page so that people are all talking about
9 the same thing. It's a document that contains
10 information used to understand activities and radiation
11 protection practices at a facility, and also attempts
12 to flesh out the source terms that were there -- what
13 types of radionuclides were there, what quantities were
14 there, what chemical forms were there. And if you can
15 marry those source terms with the radiation protection
16 practices, particularly if you had decent monitoring
17 data, then one should be able to move dose
18 reconstructions forward.

19 One thing I'd like to say -- I think at the
20 Board conference call we had, it was discussed -- I
21 brought up the issue at one point that the site
22 profiles did not intend to be comprehensive evaluations
23 of incident reports, and they aren't. There are some
24 incident report -- incident type information in there,
25 some of the major incidents, but they are not all

1 inclusive for incidents. We maintain that information
2 in a separate site images database where we collect --
3 particularly the major incidents, catalog them. The
4 site images database is searchable by keyword, that
5 type of information. Some incidents are -- reports are
6 very large. I mean the criticality -- Y-12 criticality
7 incident report's very large. So I don't want you to -
8 - give the impression that we don't include incidents
9 in these, but they are not necessarily contained in
10 these documents. Particularly when you're doing dose
11 reconstructions for monitored workers, we wouldn't
12 necessarily rely on the incident reports.

13 Just as a reminder, you've seen this slide
14 before, but they are limited scope documents used as a
15 guide, a road map to dose reconstructions, and used as
16 a handbook. Again, if one has monitoring information -
17 - urinalysis, TLD, film badge measurements -- one
18 should be able to interpret, for instance, the missed
19 dose that was there if a person was monitored. And in
20 fact, if one looks at the internal dosimetry
21 calculations that we do in many of these dose
22 reconstructions, they almost presume that incidents
23 occurred.

24 If one has a well-established monitoring
25 program and you look at a bioassay point that was non-

1 detectable, we will assume that some sort of incident
2 or chronic exposure occurred between those two periods
3 and assign some sort of dose for that monitoring
4 period.

5 These are dynamic documents. They are
6 subject to revision any time we feel we have
7 information available to us that was discovered that is
8 new and would affect the dose reconstruction outcome
9 for any of our claimants.

10 Again, they're a compilation of technical
11 documents. There's six separate chapters. Each is a
12 stand-alone chapter, so that when it's ready it is
13 signed as a stand-alone document and if it can be used
14 for a dose reconstruction -- to accomplish a dose
15 reconstruction, it will be. We do not require that all
16 six documents be signed and compiled for that
17 individual chapter to be used. We call the individual
18 chapters, if you remember, Technical Basis Documents.
19 The compilation of all six would be called a site
20 profile.

21 I want to say a little bit about the internal
22 and external dose areas. There's been a number of
23 questions since the last Board meeting that I've
24 received from various sources regarding the concept of
25 missed dose versus unmonitored dose. Those concepts

1 are not necessarily addressed in the site profile, but
2 are included in our implementation guides. So if a
3 worker were monitored routinely, for every monitoring
4 period we would assess and attempt to assign the missed
5 dose; that is, what dose could the worker have received
6 and had all of his measurements show up as non-
7 detectable.

8 The example I would use is if you wore a film
9 badge and every month they exchanged the film badge and
10 that film badge could see no less than ten millirem,
11 for an upper limit we would assign a 121 millirem dose
12 to that monitored worker. There'd be a distribution
13 about it, but the upper limit would be 120 millirem.

14 If a person were unmonitored, it is not
15 necessarily appropriate to assign missed dose to
16 unmonitored workers. In fact, it shouldn't be assigned
17 unless one can demonstrate fairly conclusively that the
18 missed dose would conservatively estimate the person's
19 unmonitored exposure. An example I like to use in
20 those situations are if a person was monitored for ten
21 years and had non-detectable dosimetry results every
22 time for ten years, and based on that they were removed
23 from the monitoring program because they had very low
24 potential for exposure and they did exactly the same
25 job for the next two years, it may be appropriate to

1 substitute missed dose for that unmonitored dose if we
2 can demonstrate that that job was the same. But we
3 have to be careful there. It's not always an
4 automatic. It has to be done with very good
5 justification.

6 I hope that clarifies it 'cause I think it's
7 a -- they're difficult concepts to grasp. They're sort
8 of abstract, but we do assign -- and this is covered in
9 our implementation guides. We do assign missed dose
10 and we are recog-- we recognize unmonitored dose. An
11 unmonitored dose cannot necessarily be substituted with
12 missed dose unless there's some very careful analyses
13 done.

14 Looks like I got a little tab out of place
15 here, but we have issued six site profiles for DOE
16 sites. I don't normally think of Huntington Pilot
17 Plant and Mallinckrodt as DOE facilities, but that's in
18 fact that way the OWA -- Office of Worker Advocacy --
19 web site lists them. They're considered DOE
20 facilities, so I've included them in this list. Many
21 of these -- these have been done previously. I think
22 the new ones on this list -- Rocky Flats is completed.
23 That will allow us to start investigating 834 claims
24 from that facility. Oak Ridge Y-12 is fairly recently
25 completed. There's 2,088 claims from Y-12. And just

1 Friday we approved the Iowa Ordnance site profile,
2 which I believe there's around 400 claims from that
3 facility -- 500 claims from that facility. So we've
4 made some very good progress. I think collectively, if
5 you add these up, you get somewhere around 7,000 cases
6 that are affected -- that are from these different
7 sites, and that represents somewhere approaching 45 to
8 50 percent of our claimant population -- not 50, about
9 40 percent of our claimant population is covered by the
10 current site profiles in place at DOE facilities. So
11 we've -- I think we've made some pretty good progress.

12 I do want to point attention to the fact that
13 I've said "issued" and not "completed". We do, when
14 necessary, issue a site profile without having every
15 single piece of information in there. We will reserve
16 sections -- I think the Board has become familiar with
17 this. For example, at Rocky Flats in the external
18 dosimetry Technical Basis Documents the neutron
19 monitoring section for certain time periods is listed
20 as reserved. We just can't use it. It's -- we're
21 still trying to work out the details of what the
22 neutron exposures really were during those time
23 periods, but in fact anyone who didn't work in those
24 time periods and had low potential for neutron
25 exposures, we could start evaluating those cases. So

1 that's the concept of pushing these out as soon as we
2 feel that they're technically accurate, complete enough
3 to address certain blocks of dose reconstructions. And
4 then we continue to move forward with the completion
5 after the fact.

6 They're also subject to revision. The
7 Mallinckrodt site profile is undergoing revision one as
8 we speak. If you remember from the St. Louis Board
9 meeting, there were several gaps in that profile. It
10 did not address exposures from decommissioning
11 activities between 1959 and '61; also did not address
12 residual contamination from '62 to 1995. So we're
13 trying to flesh out those blocks of information so that
14 we can move more Mallinckrodt claims through the
15 process. I think Hanford site profile's also
16 undergoing some limited amount of revision.

17 And most of these revisions tend to be
18 additions to the information that we couldn't use
19 before. However, occasionally a site profile will be
20 modified from a technical perspective that may change
21 the dose reconstructions that we have previously done
22 with them, and of course if that happens, we are
23 committed to going back and looking at all dose
24 reconstructions that have been through the Department
25 of Labor process and denied and evaluating what effect

1 those changes may have on the previous dose
2 reconstructions. It's not an easy task, but we're
3 committed to doing that.

4 Okay, this -- Dick Toohey likes to call these
5 a measles chart -- really tries to depict where we are
6 in the process. And a green circle is draft complete
7 and in comment resolution. What this means is for
8 these sites all of the site profile, the individual
9 Technical Basis Documents, are complete and in draft
10 form and have been seen by OCAS, the Office of
11 Compensation Analysis and Support, so we're in comment
12 resolution. We have some issues to iron out with ORAU,
13 some technical issues -- some are substantive, some are
14 not; it depends on the individual site. But I think
15 it's very interesting to note that all but five of
16 these sites are actually very near completion. So if
17 you add that to what I just showed on the previous
18 slide, we have a fair number of these DOE sites very
19 nearing completion.

20 Once these are all done, we will have covered
21 site profiles -- we have site profiles that will cover
22 about 80 percent of the cases that we have in house.
23 So that's a major success story, I think, on our part
24 and on ORAU's part.

25 I know the question's going to be asked:

1 Well, when are all of these going to be done? And
2 that's difficult, but I think you could understand that
3 if we have drafts in hand and we're ironing out the
4 details, we're not talking six months, a year. We're
5 talking a matter of months before all of these are --
6 should be finalized and ready for use.

7 That doesn't mean, though, that there won't
8 be small pieces of each individual Technical Basis
9 Document that will need to have some additional work to
10 flesh out some neutron dosimetry issue or some
11 unmonitored period that we can't quite figure out
12 without additional research.

13 I'll point out that this Iowa Ordnance Plant
14 is now done. It can be taken off the list. Iowa
15 Ordnance is a unique site. All the major DOE sites
16 have these individual chapters. Iowa Ordnance is
17 somewhat handled more like an Atomic Weapons Employer
18 site. It's -- it had a limited operation for -- from
19 DOE activities, and so it's covered with one -- one
20 document rather than having these individual approved
21 chapters.

22 There's additional site profiles under
23 development. I've listed them here. ETEC is the
24 Energy Technology Engineering Center a/k/a Rocketdyne,
25 General Atomics -- I mean there's a number of different

1 facilities imbedded in -- or connected with that
2 facility, but it's in California, 123 cases there. If
3 one adds up these claims, that will enable another
4 1,400 cases to move forward.

5 It's not exactly 1, 400 cases, though,
6 because some people work at multiple sites and so it's
7 not an exact number, but it gives a fairly good
8 approximation, within about 20 percent I think of the
9 number of cases we could cover. Particularly at AWES
10 people didn't tend to jump around as much as maybe some
11 of the DOE facilities, like the Oak Ridge reservation.

12 So these are under construction. Weldon
13 Springs is a key one for us to finish to be able to
14 move a number of Mallinkcrodt claims forward because a
15 number of people that worked at Weldon Springs when it
16 closed down moved to Mallinckrodt. That's one reason
17 why you're not seeing more Mallinckrodt cases being
18 completed. We just have not finished this site
19 profile.

20 Again I know I'm going to be asked a question
21 about time frame. I think the best I can say is we're
22 hoping to have -- and this is a goal -- these completed
23 by end of summer or early fall. That's our target goal
24 for the remaining ones.

25 Once we get below a certain number of cases

1 for a site profile, we have to make a decision. Do we
2 really want to invest the resources to generate a
3 fairly extensive document that requires a lot of
4 resources, or is it better just to do an individual --
5 what we tend to call hand-crafted dose reconstructions
6 at those facilities. I think after these are done,
7 we're probably getting there.

8 I'd just like to switch gears a little bit
9 and talk about the site profile -- what we call site
10 profile roll-outs and the worker input activities that
11 we've been trying to go around and obtain. ORAU, at
12 the last meeting I indicated, had written a draft
13 worker outreach plan. That document is now in fact
14 completed and it's available here for distribution. I
15 don't know if it's been passed out to the -- okay, so
16 you all should have a copy of that. This is a
17 controlled document that was written by ORAU, reviewed
18 by us and approved by us, that essentially sketches out
19 what the intent of this program is, and I just
20 reiterated what the bullets are here. It establishes a
21 worker outreach group. That worker outreach group is
22 headed up by ORAU, Bill Murray -- who many of you may
23 know -- is the ORAU representative there. Vern
24 McDougal is also on board. He's a subcontractor to
25 ORAU from ATL.

1 They have also just recently hired -- many of
2 you may know Mark Lewis, formerly of the Portsmouth
3 facility. He is now actively engaged in arranging
4 these worker reach-out meetings for us. We had a very
5 successful, I think, meeting at Portsmouth last week.
6 It was Mark's inaugural meeting and I'm very excited.
7 I think that -- I see a lot of energy going into these
8 meetings and I'm looking forward to productive input
9 from these sessions.

10 They do provide an excellent input for worker
11 -- worker input. As you recall, the site profiles --
12 we were -- it was indicated to us that they were --
13 they tended to be written in a vacuum, which we agreed,
14 so we needed to go out to the workers, meet with the
15 workers, get their input, let them know what these
16 things are about, what type of information we may be
17 missing or what they can share with us. This has been
18 particularly productive -- I mentioned Portsmouth was a
19 good example of that, good information-sharing.

20 The building trades of course also have a
21 unique perspective on what was done and what was
22 monitored that we need to incorporate. And in fact, we
23 are committed to adding construction activity chapters
24 to several of the site profiles to help flesh out those
25 -- those gaps that we perceive to be there.

1 These are -- we haven't done any public
2 briefings yet, although we may be close at one
3 facility. Occasionally you go to these sites and it
4 appears that the lack of information is fairly low
5 about the programs in general, about the difference
6 between Subpart B and D and who does what. At that
7 point, you know, we have to make a decision. Is it
8 worth just having a public outreach type meeting to --
9 for a general education session to get the information
10 level up there.

11 We do take minutes at these meetings. It's
12 not to intimidate anybody, but it's just to, you know,
13 capture what we've done on paper, and we'll distribute
14 them to a representative at the meeting to be
15 distributed to the workers. We take a sign-up sheet
16 and basically, you know, get people to input and say is
17 that what we discussed, have we captured the relevant
18 issues that you -- you rose (sic) at this meeting. All
19 of this is detailed in that plan that's been
20 circulated.

21 This is a listing of some of -- well, the
22 worker input meetings that we've had so far. We've had
23 five meetings. If you notice, we're going on our third
24 one at Hanford on the 22nd -- that's Thursday after the
25 Board meeting. Thursday morning we're meeting with

1 PACE, and I believe the Guard union representatives.
2 Sometimes it's difficult to get everybody together in
3 one room on the same day, and we're sensitive to that
4 so we try to accommodate where we can. Of course we
5 prefer to make fewer trips, but if it requires us to
6 make multiple trips to a site, we will do that.

7 So we've done Hanford, we've done three
8 meetings there. Savannah River was our first one, as
9 you recall, on November 11th. Portsmouth we had March
10 24th and April 16th. And these are upcoming: INEEL is
11 next Wednesday, I think, April 28th; Nevada Test Site
12 is tentative for May 10th, and Pantex is scheduled for
13 June 3rd. All these have been scheduled since Mark
14 Lewis has come on board, so you can tell that he's
15 ambitious to get things rolling, and we really
16 appreciate his enthusiasm. I believe we have some
17 tentative negotiations going on with the Mound site in
18 May.

19 One thing that's come up at these meetings is
20 that the site safety reps need some training. This
21 came up at the Portsmouth meeting and I've heard this
22 from other union representatives before, that there's
23 enough claims being distributed now and the workers are
24 going to their union representatives and asking for
25 interpretation -- what does this mean; you know, what

1 is an OCAS-1 and should I sign it and what is this IREP
2 program and IMBA? So it's happened enough times that
3 we realize that there's a need for this training and we
4 are in the early stages of planning a workshop for --
5 we're going to invite union representatives from the
6 major sites -- hopefully health and safety type
7 representatives -- invite them to Cincinnati. We'll
8 fund the meeting at our expense to come there and have
9 a one or two-day session -- we're not clear yet on how
10 long it would take -- to essentially have a dose
11 reconstruction workshop. Start with the regulation, go
12 over the efficiency process, talk about IREP, IMBA, how
13 do you read an IREP input sheet, all that kind of
14 stuff. And hopefully to give people a baseline of
15 knowledge that they're comfortable with with the
16 process that we're doing.

17 I understand it's a complex process. It's
18 very difficult to understand these things. I don't
19 know that we'll ever get there where people will be
20 totally comfortable. But to the extent that we can
21 provide some education and input, we're committed to do
22 it and I look forward to working with the unions -- in
23 the very near term; I don't want this to drag on for a
24 long time -- to come to Cincinnati and collaborate with
25 us and to getting this information shared.

1 That's all of the formal remarks I had. If
2 there's any questions, I'd be happy to answer them.

3 **DR. ZIEMER:** Okay, let's start with Gen
4 Roessler, then Jim Melius.

5 **DR. ROESSLER:** Early on in the goals of the
6 -- doing the site profiles, you talked about meetings
7 with old-timers -- I don't know if that's the word that
8 was used, but the workers and the people who were
9 around there, if they're still available, in the '40's.
10 And at Hanford I think that's particularly important to
11 get that perception from the people who were really
12 working there during the '40's and maybe during things
13 like the green run. Have you -- what success have you
14 had with getting people like that?

15 **DR. NETON:** I'll be honest with you, haven't
16 done a lot in that area, but we are collecting data and
17 information. Matter of fact, just this morning I was
18 speaking to a fellow that's at this meeting who we're
19 going to interview. He had a -- interesting knowledge
20 -- level of knowledge, fascinating knowledge about what
21 happened in the early monitoring days for construction
22 workers -- or more specifically, what didn't happen.
23 So we're trying to do that. We need to do more of
24 that. But you know, we'll see how it goes. Right now
25 we've -- we're committed to interviewing two or three

1 people -- I think we did one interview at Rocky Flats
2 for a person who we had discovered had some knowledge
3 and was getting ready to retire, but you know, our
4 involvement there has been limited. We need to -- we
5 need to aggressively pursue that more.

6 **DR. MELIUS:** Yeah, I have a few questions.
7 The first is an item from last meeting -- actually
8 several meetings ago, also, but from my understanding
9 from last meeting was that ORAU was -- and NIOSH were
10 developing a conflict of interest policy regarding --

11 **DR. NETON:** Right, right, I'm glad you
12 brought that up because it was in my notes and I
13 skipped right over it. Thank you.

14 ORAU has drafted a conflict of interest
15 policy. We are -- we are still in the process of
16 reviewing it, but I will say that the revisions that
17 they've made to their conflict of interest plan are
18 very similar to the concepts that are included in their
19 dose reconstruction conflict of interest policy, so
20 that any worker who had worked at the site -- currently
21 works or previously worked at that site could not be a
22 principal author of one of those Technical Basis
23 Document chapters. That doesn't preclude, though, them
24 from using resources, site subject matter experts as
25 resources to help flesh out and author those chapters,

1 because we really frankly believe that they have to.
2 Those people are the most knowledgeable. But the
3 person who puts pen to paper or whatever you want to
4 say is -- cannot be -- you know, have that conflict of
5 interest. And for the new profiles being developed,
6 ORAU -- even though the official policy is not approved
7 -- is following that voluntarily at this point until we
8 review and approve their completed conflict of interest
9 modification.

10 **DR. MELIUS:** I don't know how to ask this.
11 It would be helpful to see it and -- I mean you say
12 you're following it, and yet we can't see it.

13 **DR. NETON:** I understand, Dr. Mel-- yeah,
14 it's -- until we get the final form out, I can't -- I
15 can't authori-- or issue it, but it's extremely close.
16 I mean I imagine this will be within a matter of weeks
17 that we can get this thing issued.

18 **DR. MELIUS:** Well, if we can get a -- 'cause
19 I think it's a significant problem and frankly people
20 are going to be skeptical until they -- they see it and
21 see how it's being implemented.

22 And just a comment on what you have briefly
23 described is I think one of the major issues is going
24 to be transparency if there are -- you're going to
25 access or use people with potential conflicts of

1 interest or whatever you want to call that as a
2 resource, at least there ought to -- there should be
3 some transparency to that, and I think it's really
4 transparency for all your references for this 'cause I
5 think that would be --

6 **DR. NETON:** I agree.

7 **DR. MELIUS:** -- very helpful and --

8 **DR. NETON:** Yeah, anyone who works on the
9 profile as a member of the team needs to file a
10 biographical sketch -- you know, they will have a
11 signed biographical sketch indicating that conflict of
12 interest and what their role was. But you're right,
13 until we get that formal policy issued, it's -- you
14 know, you can't tell.

15 **MR. ELLIOTT:** Can I comment here on that
16 issue? We agree, I think, very strongly that whoever
17 contributes to these documents needs to be so
18 referenced. And I think you'll see this conflict of
19 interest plan come out, as Jim has described it, that
20 will make sure that the principal authors -- who
21 interpret what is provided to them, what resources they
22 have -- are not conflicted. And as soon as we have
23 this conflict of interest plan approved, I assure you
24 we'll give it to the Board the day it happens.

25 **DR. MELIUS:** We'll give you a day or two.

1 **MR. ELLIOTT:** I'm committed on the record,
2 the day it happens.

3 **DR. MELIUS:** Okay, okay. Appreciate that.
4 And I think also -- I mean references to people who are
5 at these outreach meetings you're having, the so-called
6 "old timers" that Gen mentioned I think would be -- are
7 also -- I think it's helpful to the credibility of the
8 process to see who was accessed. And as people go back
9 and look at how this site profile that was -- you know,
10 may have been used for their dose reconstruction, I
11 think it really adds to the process.

12 **DR. NETON:** We are committed to putting the
13 minutes of those meetings on our web site, as well as
14 the attendance sheets. And I think we make it clear at
15 the meetings that we plan on doing so, so if anyone has
16 a problem with that, they can -- they can withdraw
17 their name.

18 **DR. MELIUS:** You have me a little confused on
19 another point, some of the clarifications you did at
20 the beginning -- and this has I think some implications
21 on what the Board's going to be doing in terms of
22 review process. And you mentioned I think three
23 different -- you have sort of the site profile
24 technical document which you describe in a chapter, so
25 forth. You have these implementation guides which I

1 take it -- I wasn't clear whether those were site-
2 specific or more general.

3 **DR. NETON:** No, implementation guides are
4 more general. Like we have an implementation guide for
5 internal dosimetry, an implementation guide for
6 external dosimetry. Those are more conceptual-based,
7 how would one perform a dose reconstruction giving a
8 set of bioassay records or a set of TLDs, how do you
9 correct for where the organ is relative to the badge,
10 those type of issues.

11 **DR. MELIUS:** So -- I mean those are something
12 we as a Board have to think about how we -- do. But
13 then the third one was this repository of incident
14 reports and so forth?

15 **DR. NETON:** Well, it's not just incident
16 reports. I don't -- I don't want to give you a mis-
17 impression of that. It is what we call a Department of
18 Energy site images database. We do a lot of data
19 capture efforts at facilities. We have scanned I don't
20 know how many thousands of pages of records, but
21 they're all catalogued on our database as PDF files by
22 site. So for instances if one wanted to look at all
23 the records we've captured at the Savannah River Site,
24 one could go to that section of the database and do a
25 keyword search and pull up anything that had "incident"

1 or "accident" in the title and retrieve those type of
2 documents. So it's not just purely an incident
3 database, but the incidents are catalogued in that.

4 **DR. MELIUS:** Are they -- those referenced or
5 indexed anywhere relative to the site profile technical
6 document? I mean how do we -- how do somebody from the
7 outside know what you have and -- information you have
8 and -- and don't have and -- I'm assuming internally
9 you --

10 **MR. ELLIOTT:** Well, these are all indexed.

11 **DR. NETON:** We can generate an index of
12 what's in there. I mean that are put in there, but
13 they're --

14 **MR. ELLIOTT:** And the Board certainly has
15 access to that, as well as your contractor.

16 **DR. MELIUS:** Uh-huh.

17 **MR. ELLIOTT:** And if -- correct me if I'm
18 wrong, Jim. If one is -- one of those are used in a
19 dose reconstruction, that's cited in the dose
20 reconstruction report, are we --

21 **DR. NETON:** Yeah.

22 **MR. ELLIOTT:** -- incident report was found
23 and such and such a date cited from --

24 **DR. NETON:** Yeah, if it were used in the dose
25 reconstruction, I mean the first ones we did were the

1 Y-12 criticality accident and those are referenced.

2 DR. MELIUS: But they're not referenced in
3 the site profile technical document.

4 DR. NETON: There are some referenced in
5 there, but it's not an exhaustive list. The problem
6 you have with incident reports and investigations,
7 where do you draw the line? Do you draw the line at
8 these little episodic two or three-people incidents, or
9 do you have to get to a critical mass of 20, ten
10 people? We have catalogued the best way we can the
11 ones that have reports associated with them. We also
12 request all incident monitoring data from the
13 Department of Energy when we issue a request for
14 information. We also request incident information
15 during the CATI. There's numbers of sources that bring
16 these incidents to the forefront. However, in certain
17 dose reconstructions where we have monitoring data, it
18 is not necessary -- necessarily essential to have that
19 small incident in there, for example, an internal
20 exposure. If one assumes -- if you have two bioassay
21 samples and we assume for dose reconstruction purposes
22 that an incident happened the day after his last sample
23 and what could it have been and still been non-
24 detectable a month or two months later, that dose would
25 be assigned to the worker in the reconstruction.

1 So any incident that would have been in there
2 is covered in a fairly claimant-favorable manner. That
3 way we don't -- we can't possibly find all -- reference
4 to all possible internal dose incidents that occurred.
5 If we know about them, of course we'll deal with them.
6 But if we don't know, using the claimant-favorable
7 approach, we will assume some type of incident happened
8 in that period.

9 **DR. MELIUS:** Yeah, but --

10 **DR. NETON:** I don't know if that's --

11 **DR. MELIUS:** No, I understand what you're
12 saying. I think it just -- if the individual's name is
13 not attached to that in -- I'm trying to think as --

14 **DR. NETON:** Yeah, yeah.

15 **DR. MELIUS:** If this is like the -- you know,
16 the base document that's supposed to sort of guide
17 these individual dose reconstructions.

18 **DR. NETON:** Right.

19 **DR. MELIUS:** And those -- and that -- and
20 you're using these other technical documents and -- and
21 -- but that incident -- let's assume that it's a
22 significant incident, whatever that means. Okay?
23 Clearly you can't cover every single one, but there is
24 no name attached to it. It would seem to me that you
25 would want some system to be able to make that

1 association, whether it be with a building or a process
2 or a type of job that at least would raise the
3 suspicions or -- I mean, again, we're -- you're not
4 necessarily going to pick up the interview process,
5 you've got a survivor or whatever.

6 **DR. NETON:** Right. Yeah, to confuse matters
7 even more, I can talk about a different subset of the
8 data, which is this worker profile database that we've
9 talked about in the past, and that is under
10 construction, where workers' data are going in there.

11 Right now, by and large a large number of the
12 claims that we are working on have monitoring data.
13 These are -- I'm not saying we're not doing any
14 unmonitored workers, but until we get a number of
15 workers through that have monitoring data where we
16 flesh out what their exposures could have been, that
17 goes into the worker database. Then we can start
18 moving through these workers who may have been
19 completely unmonitored. It just can't happen until we
20 get some more experience at certain sites. I'm not
21 saying we're not doing any of those because there are
22 some techniques we can use to do unmonitored workers,
23 but -- but we need to gain some more experience with
24 the monitored workers who have bioassay samples and
25 TLDs to understand what happened in those areas, to

1 then be able to say okay, this unmonitored worker who
2 did this exact same job or similar job has this
3 exposure, in our estimation. I'm probably confusing --

4 **DR. MELIUS:** No, no, no -- well, probably --
5 I probably don't realize I'm confused -- do it -- when
6 I'm asking these questions, but you are using this
7 efficiency process.

8 **DR. NETON:** Yes.

9 **DR. MELIUS:** And so you have someone that has
10 monitoring and you're -- assuming that's a fairly
11 significant percentage of those that you're moving
12 through now. I don't --

13 **DR. NETON:** Yes.

14 **DR. MELIUS:** You know, the site -- and so
15 they're being excluded based on -- their -- their claim
16 is being denied based on efficiency, yet how -- then
17 how do you know whether or not you've missed an
18 incident? I mean 'cause an in-- a signifi-- a
19 significant incident, where's that --

20 **DR. NETON:** Like I say, we assume -- if
21 someone had bioassay monitoring, let's say that the
22 person was monitored every six months. We would assume
23 that the person had exposure, even though they were
24 non-detectable that whole period during their work
25 history, and give them internal dose -- whether it

1 would be -- there's a judgment call from a health
2 physi-- professional judgment call whether this was a -
3 - potentially a chronic exposure scenario which could
4 be more claimant-favorable or an episodic exposure
5 scenario. I mean it depends on the case, but we assign
6 essentially missed dose for internal exposures that
7 would incorporate or include doses from incidents.
8 That's what missed dose really is, from an internal
9 monitoring perspective.

10 **DR. MELIUS:** Uh-huh.

11 **DR. NETON:** If I assume you had an incident
12 the day after you left your last sample, then your --
13 and your next bioassay was non-detectable, there's no
14 incident that could have been greater than that. That
15 is the highest dose we could possibly come up with for
16 that un-- for that monitored period.

17 **DR. MELIUS:** Uh-huh.

18 **DR. NETON:** Those are techniques that are --
19 that are often used in the program. So there is no
20 incident that happened anywhere in that month that's
21 going to be less dose because it happened closer to the
22 monitoring period. Am I...

23 **DR. MELIUS:** Yeah, I've just been trying to
24 see how the -- we, as the Board reviewing this program,
25 captured that in our -- to make our process efficient

1 in terms of --

2 **DR. NETON:** Right.

3 **DR. MELIUS:** 'Cause if we're going to
4 approach it -- if we're going to wait until we get to
5 individual dose reconstructions, it seems to me that
6 that could be then a lot of work for each individual
7 dose reconstruction to make sure that the information's
8 complete --

9 **DR. NETON:** Right, yeah.

10 **DR. MELIUS:** -- that we have for that -- that
11 you used for that individual.

12 **DR. NETON:** I'll give you an example. About
13 a year ago I think we gave a presentation where we said
14 in certain cases where an organ doesn't concentrate
15 plutonium, for example, and the person was monitored
16 and had periodic monitoring, or maybe only one
17 monitoring, an exit monitoring point and it was non-
18 detectable.

19 **DR. MELIUS:** Yeah.

20 **DR. NETON:** In the efficiency process, we
21 could assume that the person had an acute intake of
22 plutonium on the first day of employment, and bring it
23 down to where it was non-detectable the last day and
24 give the person that whole integrated dose for maybe a
25 15 or 20-year work history. That would encompass any

1 possible incident that could have occurred in their
2 work history. I can't imagine mathematically that
3 there is a more generous assignment that one could use.

4 **DR. MELIUS:** Uh-huh.

5 **DR. NETON:** These are outlined in our
6 implementation guides, these type of concepts. So
7 those incorporate -- they preclude the use of incident
8 data because you're assuming that a worst-case incident
9 occurred at the beginning of the process.

10 I think when we start reviewing dose
11 reconstructions I'm hoping this will become a little
12 clearer, but --

13 **MR. ELLIOTT:** I know this goes back many
14 meetings ago, but we gave a presentation -- Dave Allen
15 gave a presentation on internal dose, bioassay
16 analysis, and how we proposed to do that under the
17 internal dose implementation guide. And Tim Taulbee
18 come before you and gave a similar presentation on the
19 external dose implementation guide. If you want to
20 revisit those, we can certainly consider that and bring
21 them back. They're on the web site, but we can bring
22 those guys back in and I think illustrate again what we
23 were proposing then and how we're actually doing it
24 now, how we're using that -- those methods and those --
25 those concepts.

1 **DR. NETON:** Yeah, I would be more than happy
2 that we'd come back and revisit the issue of how we --
3 internal missed dose and the efficiency process work
4 hand-in-hand and are extremely claimant-favorable in
5 many of these dose reconstructions.

6 **DR. ZIEMER:** Jim, are you asking about cases
7 where -- is there any assurance that, if we do have an
8 incident report, that it's linked to a particular
9 individual who might have been there or involved?

10 **DR. MELIUS:** There's a way of linking it,
11 that's --

12 **DR. ZIEMER:** Yeah --

13 **DR. MELIUS:** -- what is -- what method are
14 they using to link to this --

15 **DR. ZIEMER:** So let's say somebody worked at
16 Y-12 at the time of the criticality accident.

17 **DR. MELIUS:** Uh-huh.

18 **DR. ZIEMER:** Does the Y-- can you link the Y-
19 12 report with an individual whose dose reconstruction
20 occurs during that period?

21 **DR. MELIUS:** Yeah.

22 **DR. ZIEMER:** It's that kind of question
23 that's being asked.

24 **MR. ELLIOTT:** Yes and no.

25 **DR. NETON:** Yeah, I mean --

1 **MR. ELLIOTT:** Yes and no.

2 **DR. ZIEMER:** You may or may not, and I think
3 Jim is saying, for example, if it's an internal dose
4 issue and there's bioassay data, then the fact that you
5 made the linkage may not matter --

6 **DR. NETON:** For -- for -- to do --

7 **DR. ZIEMER:** -- that that's what caused it.

8 **DR. NETON:** Right.

9 **DR. ZIEMER:** On the other hand, if it's
10 someone who wasn't monitored, you might have a
11 different situation.

12 **DR. NETON:** Yeah, and that's what I was
13 trying to say. The unmonitored workers are much more
14 difficult. I mean I'll agree with that, and that's why
15 we're constructing this worker database -- these data
16 points, but we're not ignoring incidents. We're
17 cataloguing them, but we are also performing dose
18 reconstructions without necessarily having to link the
19 internal exposure to an incident.

20 **DR. ZIEMER:** But if a person worked at a
21 given site -- let's say Y-12 -- in mid-June of '58 --
22 that was the year, I believe. I happen to know that
23 'cause I was there.

24 **DR. NETON:** Right.

25 **DR. ZIEMER:** Did -- how would you link that

1 person's work with the incident, I guess is the...

2 **DR. NETON:** Yeah. Well, we have the entire
3 report. We know how many people were reconstructed in
4 that incident. It's in this database that I spoke of,
5 the Y-12 criticality incident --

6 **MR. ELLIOTT:** I think a more illustrative
7 example is the obverse question. Where we don't have
8 the ability to link, what are we doing?

9 **DR. ZIEMER:** Right.

10 **DR. NETON:** Right, and that's what I'm trying
11 to say --

12 **MR. ELLIOTT:** And we're giving the benefit of
13 the doubt. We're not challenging them in that way.
14 We're looking at the reasonableness of the allegation.

15 **DR. NETON:** Right, I think --

16 **MR. ELLIOTT:** And if they say an incident
17 happened in building X where I was working, and to our
18 best efforts we can't find that that incident was ever
19 recorded but we can get an affidavit -- okay? -- we
20 pursue that line.

21 **DR. NETON:** Yeah, I'm --

22 **DR. ZIEMER:** Okay.

23 **DR. MELIUS:** But the -- I guess my question
24 is -- well, I think it's two-fold. One is how do we
25 assure the people involved in the program, the

1 claimants and so forth, that these are -- you know,
2 incidents are accessible to you, to the extent that
3 it's possible to do this, and that in some cases there
4 may be a reported incident that's not recorded. Other
5 cases there -- you may not have -- again, 'cause it's a
6 survivor's -- you know, applying, they may not have
7 that information, yet there's some assurance that
8 there's an attempt to find that out. And I think
9 people's expectations -- some say that was -- would be
10 part of the site profile 'cause the site profile is the
11 -- what the person doing the dose reconstruction's
12 going to use as their Bible. And so I'm trying to get
13 a feeling for what is the other --

14 **MR. ELLIOTT:** But this goes to the practice
15 of dose reconstruction. It doesn't go to the site
16 profile. The site profile is a specifically-purposed
17 document that doesn't necessarily speak to incident or
18 accident reports.

19 **DR. MELIUS:** Uh-huh.

20 **MR. ELLIOTT:** But in the practice of dose
21 reconstruction, we expect each dose reconstructor to
22 ask those questions of a -- of the case and pursue that
23 line of thought until they're satisfied.

24 **DR. NETON:** I think we need to start -- when
25 you start getting into the dose reconstruction reviews,

1 it'll become more -- may become more obvious how this
2 tends to work. The profile is a guide, it's a living
3 document, a dynamic document. It helps the dose
4 reconstructor with their job to be more uniform and
5 consistent. It does not have to have every piece of
6 data that were ever existing at that site for it to be
7 used, and you see we oftentimes do publish them without
8 having the entire document completed. As long as we're
9 aware of what is missing in there and can't use it for
10 those scenarios, I think we can use it. I mean it's
11 okay. But one needs -- you cannot review a site
12 profile in a vacuum without looking at its
13 corresponding dose reconstruction that was done with it
14 to see does that really make sense. Was a good enough
15 job done on the dose reconstruction in collaboration
16 with the site profile to provide a convincing argument,
17 technically, that this is the reconstructed dose for
18 the person.

19 **DR. MELIUS:** But I think we're also looking
20 for how are you -- it's a concern of ours, it's a
21 concern of yours -- is how do you maintain consistency
22 among the cases so that the same type of information's
23 accessed, and that's to some extent what the site
24 profile would provide -- again, never -- not complete
25 and so forth, and I'm sort of thinking as our process

1 to review these, how do we do that in an efficient way
2 that, you know --

3 **DR. NETON:** Yeah, I --

4 **DR. MELIUS:** -- it helps the process, I mean
5 -- obviously would do that and -- while -- but I think
6 -- somehow I think -- you haven't convinced me yet, but
7 I --

8 **DR. NETON:** Yeah.

9 **DR. MELIUS:** -- the site profile, including
10 this -- you know, these incident (Inaudible), would be
11 one way of making sure that there was some consistency.
12 And for, you know, the claimants also to know that
13 there'd been a comprehensive attempt to get what
14 information's available for significant incidents and
15 to the extent possible -- do that. And may or may not,
16 you know, be helpful for some of the individuals --
17 individual dose reconstructions that you do. I'll
18 think about it some more --

19 **DR. ZIEMER:** Let's go ahead --

20 **DR. MELIUS:** -- and be more confused and --

21 **DR. ZIEMER:** -- Robert Presley has a
22 question.

23 **MR. PRESLEY:** Jim, do -- are y'all getting
24 any feedback from say the -- on the site profiles that
25 are out on the web site now, are you getting any

1 feedback from any type of old-timers group or what we
2 call graybeards or anything like that? And if so, are
3 there means to where that site profiles can be updated?

4 **DR. NETON:** We have not received a lot of
5 feedback. I want to say that it's a handful of
6 comments and not as many as we would have hoped, I
7 suppose. At least -- you know, the union briefings, we
8 do -- we do get feedback and got some valuable
9 information. But from the write-in, there's been some
10 -- some input. If they do provide substantive input
11 that would change the approach to dose reconstruction,
12 as I mentioned, we would certainly modify the site
13 profile to incorporate that information, put that back
14 out on our web site as a revision and then go back and
15 view its effect on all prior dose reconstructions that
16 were denied. We wouldn't go back and look at the one
17 that were awarded.

18 **MR. ELLIOTT:** If I could add to that, I know
19 that we've had one comment that resulted in our looking
20 at the source documents for a site profile to make sure
21 that we had a reference that was given to us by this
22 commenter. And I think that was valuable because we
23 did have it and we could tell them we had it.

24 In another case, a commenter gave us a
25 reference which we didn't have, and so we considered it

1 and added it and -- added it to; I don't think it made
2 any change to the site profile, but it was another
3 piece of information we hadn't had before.

4 **DR. ZIEMER:** Another comment?

5 **DR. MELIUS:** Yeah, I will just be brief, but
6 I will catch you tomorrow on your outreach plan once I
7 figure out how to read an ORAU technical procedure --
8 couldn't even figure out where -- what it was at first,
9 but -- and may have some questions tomorrow, but I'm --
10 one -- glad that you're doing it and so forth. I would
11 -- and I think the idea of doing some more educational
12 technical outreach I think is good. I would urge you
13 to work with Department of Labor in some of -- 'cause
14 it seems that Pete Turcic and DOL wants to do some of
15 the same activities. And I think to the -- given the
16 potential confusion about the different programs, I
17 think it's helpful if everyone can go out together and
18 do that, you know, within -- within resources and --
19 and so forth. But appreciate you getting this done and
20 -- I say, I may have -- if I can understand it, I'll...

21 **DR. NETON:** I apologize for getting it late,
22 but it was literally just signed Friday.

23 **DR. ZIEMER:** Thank you. Further comments?
24 Mark, yes.

25 **MR. GRIFFON:** Jim, I just need a little more

1 clarification on the unmonitored -- unmonitored workers
2 versus unmonitored exposures. And what I'm trying to
3 get at here is the -- I mean I've interviewed quite a
4 number of former workers that have -- that have said
5 there's been various jobs, various time periods where
6 they were coming close to their quarterly limit and
7 were told or -- or volunteered, in a sense, or else
8 they would be rotated out of their job, they were told
9 to leave their badge in their locker when they worked
10 for the next couple of weeks or else they'd be over
11 their limit and be shipped off somewhere else. That's
12 one example.

13 Another example is if you have all this
14 bioassay monitoring data but the source term suggests
15 that there were exposures to other radionuclides,
16 that's something I would consider a potentially
17 unmonitored exposure. You know, the worker was being
18 monitored, but maybe for the wrong thing.

19 **DR. NETON:** Uh-huh.

20 **MR. GRIFFON:** So I'm wondering if you address
21 that in your unmonitored -- in your concept of
22 unmonitored dose, 'cause you didn't really say that
23 when -- in your earlier statements.

24 **DR. NETON:** Right. Right. The first example
25 that you bring up -- brought up actually came to us at

1 one of our worker outreach briefings. A person came up
2 and brought up that exact issue, that even in fairly
3 recent times workers were pulled off a job as they
4 approached the administrative limit because -- or not
5 pulled off, but they weren't badged and they continued
6 to receive exposure. And in fact we're looking at
7 that. We're going to actually write a technical
8 bulletin on this issue where if you look at the
9 cumulative dose for workers, cumulative frequency
10 distribution, it goes up and then all of a sudden
11 towards that administrative limit, it starts to go like
12 this (indicating). And you know something happened
13 there because the workers may even still have been on
14 the bioassay program. So you can -- you can fit that
15 curve and maybe extrapolate back upwards, and we're
16 looking at ways to accommodate that.

17 That is not going to affect a large number of
18 workers, but a very important segment of workers
19 because those are the ones that are very close to maybe
20 the compensation, you know, value, so we're looking
21 very closely at that. That's not addressed right now,
22 but we're looking at ways to address that and this is a
23 good example of something that we learned at one of
24 these worker outreach meetings.

25 I think we're aware of it in general.

1 There's articles on this, but to the extent it happened
2 and to hear a real-world example at a specific site was
3 very interesting to us.

4 The second example --

5 **MR. GRIFFON:** (Off microphone) We've heard
6 that at a lot of sites (Inaudible).

7 **DR. NETON:** Yeah, I'm learning that. Yeah.
8 The second example where we have bioassay programs
9 where the source term had nuclides that weren't
10 monitored, I think -- I think that speaks to the site
11 profile. I mean the internal dosimetry site profile is
12 supposed to cover and flesh out the source terms --
13 what radionuclides were there; were there transuranic
14 nuclides mixed in with the uranium source term; were
15 there other types of materials. And then that would
16 require the health physicist to go back and reconstruct
17 those. In fact --

18 **MR. GRIFFON:** Then this also get to the
19 linkage that Jim was talking about. How do you place
20 that -- the worker -- the individual that you're dose
21 reconstructing with that source term? How do you --
22 you know?

23 **DR. NETON:** We know what years the source
24 term existed and when the transuranic wastes, for
25 instance, started coming in in the late '50's and so

1 if --

2 **MR. GRIFFON:** And do you --

3 **DR. NETON:** -- and the site profile would

4 definitely address that. That's not an incident-

5 related issue. That is just --

6 **MR. GRIFFON:** No, no, no --

7 **DR. NETON:** -- a fact -- source

8 term-related --

9 **MR. GRIFFON:** -- but -- but for a --

10 **DR. NETON:** -- fact.

11 **MR. GRIFFON:** -- work history, especially

12 for --

13 **DR. NETON:** Right, where the worker was, and

14 if we didn't know, we will assume always the most

15 claimant-favorable approach and assign the worker the

16 worst source term that existed at the site if it's not

17 possible to determine their exact location. That's

18 fairly standard practice in this program.

19 **DR. ZIEMER:** Did you have an additional

20 question, Mark? No? Okay. Question, Mark? Okay.

21 Other comments, questions?

22 (No responses)

23 **DR. ZIEMER:** Jim, thank you very much. Our

24 agenda calls for a break. We've not been back from

25 lunch for a full hour. Does the committee feel like

1 they need a break yet or you want to press on?

2 (Pause)

3 **DR. ZIEMER:** I guess we're going to have a
4 brief break -- five minutes.

5 (Whereupon, a recess was taken.)

6 RESEARCH ISSUES STATUS

7 **DR. ZIEMER:** Our next item on the agenda is
8 Russ Henshaw from NIOSH. Russ is going to give us a
9 status report on what the Board refers to as research
10 issues. These are ongoing issues that are of interest
11 to us in terms of -- relating to dose reconstruction
12 and related issues. So Russ?

13 **MR. HENSHAW:** Good afternoon. Can everyone
14 hear me okay?

I'm Russ Henshaw. I'm an epidemiologist with NIOSH's Office of Compensation Analysis and Support, and my presentation today will focus on two areas. The first is an update on research topics. And as I go through the slides you'll see that we will have projects underway within the year addressing each of the three research areas identified earlier by the Board as priority one topics.

23 The second part of the presentation will
24 focus on a review of compensation results of our
25 completed claims through the first quarter of this

1 year.

2 And Dr. Ziemer, if it's okay with you, I'd be
3 happy to entertain questions at any time during the
4 presentation or after --

5 **DR. ZIEMER:** Sure.

6 **MR. HENSHAW:** -- particularly in the second
7 part when we start looking at the -- all the data. If
8 it's unclear, please don't hesitate to ask me to
9 clarify it.

10 Just to recap the Board's earlier
11 consideration of research topics -- and here for
12 reference purposes are the topics the Board previously
13 identified as priorities. There are three priority one
14 topics and two priority two topics. And I'll address
15 each of those in the coming slides.

16 Well, this topic -- and that is the
17 incorporation of occupational studies into NIOSH-IREP -
18 - appears first on the Board's priority one list.
19 Obviously the DOE work force itself, rather than the
20 atomic bomb veterans -- excuse me, atomic bomb
21 survivors -- would be the ideal source population from
22 which to derive IREP risk coefficients. However, when
23 the risk models were first developed for IREP, NIOSH
24 judged that worker studies were insufficient from which
25 to derive quantitative risk estimates, due to a number

1 of factors but primarily because the complexity of the
2 factors in the study and also the often conflicting
3 findings.

4 The idea, though, was to periodically revisit
5 this issue, and we intend to do that this year. We
6 will conduct a feasibility study within the year to
7 review the current state of knowledge of worker
8 studies. And if it appears warranted from that review,
9 we would then propose to launch a more formal
10 evaluation leading to the possible adjustment of IREP
11 risk coefficients.

12 And this has been discussed often, the NIOSH-
13 IREP lung and smoking model. And as you know, the
14 model's a priority one topic and it conflicts now --
15 the model in NIOSH-IREP conflicts with the model
16 currently in use in NCI's version of IREP which is
17 known as NIH-IREP. NCI introduced a new lung model
18 late last year based on a new analysis of updated
19 Japanese cohort data.

20 The question was how to deal with that,
21 whether to adopt the NCI model, not adopt it, adopt it
22 in some revised form, what have you. Well, this year
23 we will have SENES convene an expert panel to evaluate
24 the new model, not to second-guess NCI's decision, but
25 to evaluate it for its applicability in our program --

1 whether it fits the unique exposure characteristics of
2 the EEOICPA-covered work force.

3 This approach could also be used for other
4 model differences. For example, the bone model. The
5 NCI model uses a slightly different latency function
6 than we do in NIOSH-IREP.

7 The other priority topic -- priority one
8 topic on the Board's list is the -- is how cancers are
9 grouped in IREP, the grouping of rare and miscellaneous
10 cancers, including prostate cancer. Well, again, we're
11 going to address that this year. In fact, SENES will
12 begin re-evaluating the risk coefficients used in IREP.
13 In particular we are asking them to focus on the
14 possible discrepancies in the uncertainty
15 distributions, especially revisiting the logic and
16 consistency in how the models were grouped in the first
17 place and wound up into one of the 32 risk models
18 currently used in NIOSH-IREP. Again, this project will
19 begin this year.

20 There were two priority two topics on the
21 Board's list. There really isn't much to report at
22 this time. The age at exposure workshop concept, which
23 has been discussed previously at Board meetings, has
24 been shelved for the time being. But it could be
25 revisited at a later date. The problem right now is

1 the lack of development of a standardized database.
2 And frankly, lack of staff time to pursue the project.

3 However, age at exposure is a potentially
4 crucial and controversial factor, so we can't let it
5 fall off of our radar. Later, by the way, when I get
6 into looking at the claims results, I have a slide
7 showing the compensation rates by exposure age. It's
8 kind of interesting.

9 Interaction with other work exposures was the
10 other priority two topic, and quite frankly we've
11 discussed this from time to time within OCAS, but we
12 simply have not had time to properly consider it.
13 There's nothing currently planned.

14 There of course are other potential research
15 topics other than the five on the Board's priority one
16 and two list. One of those is DDREF or dose and dose-
17 rate effectiveness factor. And as you probably know,
18 DDREF is a risk modifier that's used to adjust for low
19 level radiation doses just for the non-leukemia
20 cancers. The leukemia models employ a linear quadratic
21 function which it's thought adjusts already for that
22 issue.

23 Actually the first phase of this project is
24 already nearing completion. The first phase was an
25 extensive literature review that SENES has been doing -

1 - they began that earlier this year, and we expect to
2 have a progress report from SENES within a few weeks.
3 Once the report is in, we will review SENES's tentative
4 findings and recommendations. The next phase then
5 would likely involve convening an expert panel, but
6 we'll wait for the written report before commenting
7 further on that.

8 And then there is chronic lymphocytic
9 leukemia. As the Board knows, there was a
10 Congressional appropriation for research specifically
11 on CLL. CLL is of course the only cancer specifically
12 excluded from compensation in IREP. It's been
13 traditionally regarded as a non-radiogenic cancer.

14 However, there are other cancers with very
15 little evidence for radiogenecity and we have
16 quantitative risk models for those cancers in IREP.
17 For example, prostate cancer, non-Hodgkins lymphoma,
18 and even some of the leukemia subtypes like hairy-cell
19 leukemia that is granted some risk in NIOSH-IREP,
20 whereas for example the United Kingdom compensation
21 program excludes hairy-cell leukemia as well as CLL.

22 At any rate, our Health-Related Energy
23 Research Branch, otherwise known as HERB, will begin a
24 research project on CLL this year. That will include
25 an acceleration of two leukemia studies already in

1 progress -- two of their own studies -- as well as a
2 meta-analysis of other relevant studies, both published
3 and unpublished. And they also intend to convene an
4 expert panel, and I believe their plan is to do that
5 this summer.

6 If the findings from this study warrant it, a
7 quantitative risk model for CLL could be developed and
8 incorporated in NIOSH-IREP.

9 **MR. ELLIOTT:** Russ, may I interrupt you just
10 a moment?

11 **MR. HENSHAW:** Sure.

12 **MR. ELLIOTT:** I just want to make note here
13 that each of these scientific expert panels or
14 technical peer panels, subject matter expert review
15 panels, whatever you want to call them, whatever the
16 findings and recommendations are from those, we would
17 then bring forward to this Board.

18 **MR. HENSHAW:** Right, thanks, Larry. Just
19 following up on that, they're -- in addition to the
20 Board's own discussion of procedures for modifying
21 IREP, that's also spelled out in the probability of
22 causation rule which requires us to submit proposed
23 substantive changes to the Board for review and to then
24 consider those -- the Board's comments, if any. Also
25 to notify the public via the *Federal Register*, consider

1 those comments, et cetera. And then finally to notify
2 the Board, the public and the Department of Labor of
3 the expected completion date for implementing any
4 change after we've gone through that process.

5 There's a provision to deviate from that --
6 those procedures, and again, those are the procedures
7 in the probability of causation rule -- to deviate from
8 those if circumstances warrant. It does not explain
9 what those circumstances need be, but that -- that
10 option is there. And a substantive change is defined
11 as -- a substantive change to NIOSH-IREP is defined as
12 any change that would substantially affect probability
13 of causation.

14 Now this is maybe only marginally a research
15 topic, but since we're doing it right now, I thought
16 I'd report on it. As you may know, the guts operating
17 in the background of NIOSH-IREP is a software program
18 called Analytica 2.0. Analytica released a newer
19 version earlier this year, Analytica 3.0, and it
20 addresses, for our needs, some of the limitations
21 inherent in the older software package. 2.0 was
22 limited by capacity, and by that I mean the number of
23 rows of dose input that IREP can effectively process,
24 as well as the number of iterations used. You might
25 recall that most claims are run using 2,000 iterations

1 in the Monte Carlo simulation process. Claims that
2 initially fall into the 45 to 50 percent range but do
3 not meet the compensability level of 50 percent
4 probability of causation, we use a -- we up the number
5 of iterations to 10,000 for a more precise estimate of
6 probability. At any rate, IREP is currently limited to
7 -- at 10,000 iterations, probably no more than 300 rows
8 of dose input. What we're finding lately is that some
9 claims can have considerably more dose input than that,
10 up to 500 rows or even more. So 3.0 would solve that
11 problem.

12 However, before changing over to it, we need
13 to thoroughly test the software to ensure that there
14 are no inadvertent effects on PC results, either due to
15 rounding or some other unanticipated glitch in the
16 software. And we are doing that. We're working
17 cooperatively with ORAU and SENES to accomplish that.
18 We have a test planned that actually is probably just
19 getting underway this week, if not last week.

20 And finally, the research part of the
21 presentation, I thought I'd mention the potential use
22 of our own claims data. It's possible that an epi
23 analysis of claims data could prove useful in the IREP
24 risk model. I say possible because there are
25 limitations and some very serious challenges to the

1 data, but it's still possible.

2 To begin with, the data are currently
3 limited. The results should not be construed as being
4 representative of all claims, not by any means. But
5 more importantly, the dose reconstruction efficiency
6 approach carries very serious limitations, especially
7 when attempting to assess dose response.

8 Right now -- you'll see as we get into the
9 slides, results are based on 1,325 completed claims.
10 Of those claims, with the exception of the claims from
11 Bethlehem Steel, a claim -- any claim that's
12 compensable -- virtually all compensable claims use the
13 underestimate approach. Virtually all non-compensable
14 claims use the overestimate approach. What that means,
15 for my purpose -- our purposes for trying to do an
16 epidemiological analysis, is that for compensable
17 claims the dose reconstruction stops when enough dose
18 is found to make the claim compensable.

19 The converse of that, for a non-compensable
20 claim, an extreme overestimate is used. If the extreme
21 overestimate is still below -- would still result in a
22 probability of causation below 50 percent, again the
23 dose reconstruction stops. Therefore, we have few, if
24 any, claims with complete dose reconstructions.

25 Again that efficiency process -- I believe

1 Bethlehem Steel would be the exception to that where --
2 it was a kind of -- I don't know whether it's a unique
3 site, but it was a site with I believe no personal
4 monitoring data, so the model applies I think to all
5 the claims.

6 Other challenges are in comparing the data
7 with National Cancer figures. It's difficult to do
8 under the best of conditions. Also there are hundreds
9 of different types of cancer, but less than three dozen
10 cancer models in NIOSH-IREP. And finally, the
11 claimant-friendly process further complicates an
12 epidemiological analysis of the completed data, as in
13 many cases we use multiple IREP models and take the
14 model with the highest probability of causation, and
15 that is the information that appears in our database
16 that can be extracted for analysis.

17 I'd like to share the claims results with
18 you. Again, that's through March 31st, 2004. This
19 includes completed dose reconstructions submitted to
20 the Department of Labor for which we have received
21 notice from the Department of Labor of a decision.
22 That's about two-thirds at that time -- through March
23 31st, about two-thirds of the dose reconstructions
24 submitted to DOL. Thus it may not -- for that reason,
25 it may not be predictive of future results, but also

1 because of the efficiency process, a more compelling
2 reason, it would be surprising if it's predictive of
3 future results.

4 Another caveat is that the results for the
5 cancer -- specific compensa-- cancer model-specific
6 compensation rates reflect only claims with one primary
7 cancer. You'll see later -- I show the compensation
8 results for two other broad groups of claim types. One
9 is secondary cancers for which the primary is unknown.
10 The other is multiple cancers. Those are not included
11 in the cancer model-specific results.

12 Okay, just to -- what I've done here, I've
13 taken the 32 cancer models in IREP and put them in a
14 table. It goes across several slides. I have -- just
15 to try to explain the table here -- I hope I'm pressing
16 the right button for the laser pointer -- the column on
17 the left is the cancer model in IREP, and it's arranged
18 simply in the order that the models appear in the
19 NIOSH-IREP pull-down menu, and that's roughly in
20 ascending numerical order by ICD-9 code.

21 The middle column is the total number of
22 cases that were processed using that model -- and
23 again, these are only -- these are claims with only one
24 primary cancer. And the right column, probability of
25 causation greater than or equal to 50 percent -- equal

1 to or greater than 50 percent. There are the claims
2 that were -- the portion and percentage of -- excuse
3 me, the number and percentage of claims that were
4 compensable.

5 In this case, for example, oral cavity and
6 pharynx, there were 23 claims. Four of the 23 were
7 compensable for a compensation rate of 17 percent.
8 Oral cavity and pharynx, by the way, includes tumors of
9 the lip, tongue, gums, tonsils, et cetera.

10 Any questions on the table format or the
11 numbers before I go on to the next slide?

12 (No responses)

13 **MR. HENSHAW:** I think I'll save you the agony
14 of having me read what exactly you can see on the
15 slide, so...

16 **DR. HOFFMAN:** Russ, since we have members of
17 the public here, I think it's important to point out
18 that this is not probability of causations greater than
19 50 percent, but a one percent chance that the
20 probability of causation would be greater than 50
21 percent, and so it's a -- it's a highly conservative
22 estimate of the probability of causation.

23 **MR. HENSHAW:** I -- thanks, Owen. I think
24 what Owen -- what Owen is saying is that -- I think --
25 don't interpret the percentage in parentheses as the

1 average PC or the PC result. That's simply the rate --
2 the compensation rate, the percentage of cases that
3 were compensable.

4 **DR. ZIEMER:** I believe he was simply defining
5 what probability of causation means in this case. I
6 don't think we understood the numbers in the column to
7 be that. Owen, you were simply defining probability of
8 causation as it's applied by NIOSH, which is --

9 **DR. HOFFMAN:** Right, but in this case it's
10 not a true probability of causation. It is -- after
11 accounting for all sorts of uncertainty, if there is
12 more than a one percent chance that the probability of
13 causation is above 50 percent, then the claim is
14 eligible. But that -- that qualification isn't evident
15 here in the slide. It just says PC greater than 50
16 percent.

17 **DR. ZIEMER:** Yes, understood.

18 **MR. HENSHAW:** Thank you, Dr. Ziemer. I
19 misunderstood what Owen said. I'm sorry.

20 Anyway, going on to the next slide, in the
21 next five models as they appear in the IREP pull-down
22 menu --

23 **MR. GRIFFON:** Russ, I was just going to ask
24 one thing.

25 **MR. HENSHAW:** Sure.

1 **MR. GRIFFON:** Do we -- I think we've asked
2 for this kind of data before and I'm not sure -- it
3 might be more appropriate in tomorrow's discussion, but
4 do we have a breakdown of number of claims by cancer
5 type by site or something like that? I think -- I
6 don't know if we --

7 **MR. HENSHAW:** Whether or not the claims were
8 processed, you mean?

9 **MR. GRIFFON:** Yeah, just in -- in terms of
10 our case selection process it might be important for us
11 to see, you know, how -- how that distribution is
12 across all the claims currently in the system.

13 **MR. HENSHAW:** I have some results. I did not
14 include that in this presentation since I was focusing
15 on completed claims. But roughly, if you consider all
16 claims submitted -- sent to NIOSH from the Department
17 of Labor, about 34 percent of the cancers are non-
18 melanoma skin cancers; 14 percent fall into the all
19 male genitalia model, it's mostly prostate cancer;
20 about 12 percent --

21 **DR. ZIEMER:** Let me interrupt --

22 **MR. GRIFFON:** (Off microphone) (Inaudible)
23 something you can --

24 **DR. ZIEMER:** Yeah, we don't need that now,
25 and you're giving the overall. I think Mark is asking

1 -- for example, does some particular cancer appear to
2 be, at least claim-wise, more prevalent at Savannah
3 River, for example, or at Hanford -- and maybe --

4 **MR. GRIFFON:** (Off microphone) Looking at
5 both, I think (Inaudible) --

6 **DR. ZIEMER:** Right, and maybe at some future
7 point or next meeting we could have that, or earlier,
8 perhaps. I think as we get into the selection process,
9 it might be helpful information. But please proceed.

10 **MR. HENSHAW:** The simple answer then is I
11 haven't looked at that yet, so --

12 **DR. ZIEMER:** But it could be retrieved.

13 **MR. HENSHAW:** One clarification on the all
14 digestive model, by the way, that is all digestive
15 except for the organs that have specific cancer models.
16 So for example, liver cancer would go into its own
17 model, gall bladder, et cetera. Anything that doesn't
18 fit into that -- for example, tumor in the small
19 intestine would go into the all digestive model.

20 You can see lung cancer is a very high
21 compensation rate thus far, 91 percent of the 230
22 single primary lung cancer claims, only 21 were non-
23 compensable. Some of this data is graphed a little
24 later, as well. And the lung model, by the way,
25 includes cancers of the trachea and bronchus.

Going on -- other respiratory, compensation rate of about 32 percent thus far. And other respiratory would include probably largely cancers of the pleura. For example, most of the mesotheliomas would fall into this category, but also the larynx and nose, except for skin cancer of the nose.

Basal cell carcinoma model, the bottom row, it's a relatively high compensation rate thus far, 44 percent.

Any questions before I move on?

(No responses)

MR. HENSHAW: The other non-melanoma skin cancer model in IREP is squamous cell, and as you can see, that is a much lower compensation rate, which basically one might speculate mirrors the fact that squamous cell carcinoma is thought to be much less radiogenic than basal cell carcinoma.

There is a separate cancer model in IREP for ovarian cancer. That's because the epidemiologic evidence is much stronger for radiogenicity for the ovaries. All other female genital organ tumors fall into the female genitalia excluding ovary model. Thus far from this dataset, none have been compensable.

That's kind of a stunning number at the bottom, all male genitalia. That is about -- well, 219

1 cases. None in this dataset have been compensable.
2 And of those 219, about 95 percent were prostate
3 cancer.

4 Going on, bladder cancer and then urinary
5 organs excluding bladder, that has a relatively high
6 compensation rate. That is -- that is a model that
7 renal cancer would be processed in, cancer of the
8 kidney.

9 Nervous system models, ICD-9 codes 191 and
10 192 -- 191 is for brain tumors, 192 is cancer of other
11 organs in the nervous system, no compensable cases thus
12 far with this data.

13 And similarly for thyroid cancer, 14 cases,
14 none were compensable. This -- there are a number of
15 surprises in these results, but I certainly was
16 surprised when I first looked at many of these numbers.
17 I would caution the Board, though, to bear in mind that
18 these results almost certainly will change. With
19 thyroid cancer -- I don't know this yet, I haven't
20 checked into it this closely, but it's quite possible,
21 for example, that someone did a dose reconstruction on
22 a thyroid cancer at a very low dose, learned how to do
23 it and then, you know, culled other low dose thyroid
24 cancers out of the claims database and did those as
25 part of the efficiency process. It may be that

1 there'll be another batch of higher dose thyroid
2 cancers which will completely change the way the
3 results look.

4 I do intend to follow this and other trends,
5 of course, as we get ongoing in the program.

6 I see a fairly large number of claims fell
7 into the lymphoma and multiple myeloma model, very few
8 of which were compensable, two out of 90.

9 And finally we go to the leukemia models.
10 There are four leukemia models in IREP. You see the
11 first two here. The other two are on the next slide.
12 They all have varying rates of compensation. For this
13 dataset there were fewer than ten claims -- that is
14 completed dose reconstructions submitted to DOL for
15 which we've received notice -- fewer than ten claims in
16 each of the four leukemia categories. If you lump the
17 four -- the numbers from the four leukemia categories
18 together, however, that's a total of 24 cases, 16 of
19 which were compensable, for a compensation rate of 67
20 percent.

21 You kind of -- you kind of draw a line right
22 there separating the last of the leukemia models from
23 the next two categories and summed up the 32 cancer
24 models, that would be a total of 1,071 claims. There
25 are an additional 254 claims, however, that I did not

1 include in the cancer model-specific categories because
2 there's really no good effective or logical way to do
3 that.

4 The claims with unknown primary cancer, there
5 were 28, 24 of which were compensable. Those are -- in
6 this case, they're all secondary cancers with an
7 unidentified primary. As you may know, our protocol is
8 to run one or more of the primary cancer models
9 depending upon the secondary cancer identified, and
10 then take the model that produces the highest
11 probability of causation. There were 226 claims with
12 multiple primary cancers, 146 of those were
13 compensable, a rate of nearly two-thirds.

14 Taken all together, all completed claims in
15 this dataset, it's 1,325 claims, compensation rate is
16 33 percent.

17 I took the cancer -- cancer models with
18 claims of at -- with -- excuse me. I took the cancer
19 models with at least ten claims and graphed them from
20 highest to lowest in terms of rate of compensability.
21 And again, this is not -- the vertical axis is not
22 probability of causation. That is the compensation
23 rate. This recaps what you've seen in the table. The
24 highest compensation rate was lung cancer, followed by
25 urinary organs excluding bladder. Again that's -- I

1 haven't looked at this to verify it, but I'm
2 speculating it's probably largely kidney cancer. Then
3 the basal cell carcinoma model, 44 percent; other
4 respiratory organs and then oral cavity and pharynx and
5 malignant melanoma at 16 percent. And going down,
6 squamous cell carcinoma, 6 percent; bladder, lymphoma
7 and multiple myeloma, and so on.

8 There were -- there were nine cancer models
9 with no compensable cases. There are only eight on
10 here. Sorry, I inadvertently omitted the all male
11 genitalia, but that should also be on this slide. Nine
12 models with ten or more completed cases, none
13 compensable thus far. I'm saying thus far, that's
14 through March 31st. I mean there may very well be
15 compensable cases in our hopper by now for some of
16 these.

17 This is just a bar graph of the two groups I
18 mentioned before, the unknown primary cases and the
19 multiple primary cases. Again, you can see very high
20 compensation rates.

21 This is a graph of compensation by years of
22 employment. I was really struck by the way this graph
23 turned out, a nice -- nice slope to the data.

24 Any questions?

25 **DR. ANDRADE:** Russ, not a question but a

1 quick comment. Perhaps you can validate this or not.
2 Isn't that slope rather artificial, given the
3 efficiency process? I mean the longer -- the longer
4 that you have worked, either at one site or more sites,
5 if you go through the efficiency process and assign say
6 missed dose over the span of your career, you're going
7 to get a linear slope.

8 **MR. HENSHAW:** I think -- yeah, that's a good
9 point. I think it's quite possible that -- maybe
10 largely due to the efficiency process, that this could
11 be a proxy for estimated dose.

12 I did the same thing with age at diagnosis.
13 Again, very nice linear slope. It also does not
14 necessarily mean anything, following up on Tony's
15 comment. It's hard to tell really what's going on with
16 this. Of course I intend to follow it and look at it
17 more closely as we get into this, but it's pretty to
18 look at, anyway, for right now. But -- kind of thing
19 if you were writing an epidemiology textbook, you know,
20 you'd invent something like that.

21 This was a very interesting observation. I
22 looked at compensation with -- I looked at lung cancer
23 compensation by smoking status. The bar on the left is
24 never smoked, the bar on the right are all the other
25 categories, including former smoker. Somewhat

1 surprisingly, the compensation rate was actually higher
2 for smokers.

3 It's hard to tell exactly what's -- I'm going
4 to show you a slide -- the next slide breaks those
5 numbers down by smoking category. It's hard to know
6 exactly what's going on there. It's something we want
7 to continue to look at as more data comes in. It
8 probably should be noted that about -- about 100 of
9 those 230 lung cases were from Bethlehem Steel. This
10 may -- this may just be a function of such an
11 overestimate -- or excuse me, such a high dose estimate
12 used that it washes out the smoking adjustment.

13 Here it is by smoking category. At 86
14 percent is the bar on the left, and again, this is not
15 probability of causation. That's compensation rate.
16 You have former smoker, less than 10 cigarettes a day,
17 10 to 19 cigarettes a day -- you can see all of those
18 categories are higher than non-smoker. It doesn't
19 start to drop until you get to more than one pack a
20 day, but even there it's a compensation rate of 75
21 percent. This -- you really can't make much of this
22 number -- I think it was only two cases, one of the two
23 were compensable. That's the more than two pack a day
24 smoker. Then the column on the right, that question-
25 marked number, that just -- that means smoker, but it's

1 unknown how many cigarettes he or she smoked per day.
2 In the risk model it's kind of an average across the
3 other smoking categories. Again, it was only a few
4 cases.

5 Any questions?

6 (No responses)

7 **MR. HENSHAW:** Compensability by gender, 37
8 percent of claims for male workers were compensable,
9 only four percent of the cases for female workers. I
10 don't know for sure what the explanation is for that,
11 but I think a good guess would be probably low dose,
12 probably less years of employment than the males.
13 About -- somewhat slightly less than half of the claims
14 -- of the completed claims for females were breast
15 cancer, by the way. I think it was like 46 percent.

16 Well, this takes me to the last slide, so I
17 guess to summarize, we will have projects underway
18 within the year addressing the three priority one
19 topics on the Board's list. We have other research
20 projects already underway or in planning. The
21 completed claims results, some surprises, but again,
22 the results are undoubtedly skewed by the dose
23 reconstruction efficiency process and also possibly by
24 the incomplete data. We'll continue to monitor the
25 data for trends and anomalies and of course we will

1 keep the Board updated as more and more data comes in.

2 Thank you very much for your attention. I'd
3 be happy to take any additional questions.

4 **DR. ZIEMER:** Thank you, Russ, for a very
5 interesting presentation. Let's see, we've got a
6 question here from Dr. DeHart.

7 **DR. DEHART:** Russ, when you were talking
8 about multiple primaries -- skin cancer, primarily
9 squamous cell and basal cell frequently are associated
10 with primary -- multiple cancers. Is that in keeping
11 with your data or do you exclude -- if they both -- if
12 they're multiple cancers and the -- three of them and
13 all three are squamous cell, how do you handle that?

14 **MR. HENSHAW:** Multiple skin cancers were not
15 included in the skin cancer-specific results. I
16 initially tried to include those cases, but it's --
17 decided it really wasn't appropriate to do that. You
18 know, we can try to do it -- look at it that way in the
19 future if you'd like, but the problem is, many of the
20 skin cancer cases are not just squamous cell or not
21 just basal cell. (Inaudible) have three or four sites,
22 two basal cell carcinomas, one squamous cell. Then the
23 problem, you know, arises which model do you put it in,
24 and then if you only count it as -- you know, most of
25 them are compensable, so do you count it as compensable

1 for basal cell, non-compensable for squamous cell, you
2 know, and so on. I finally -- I looked at that really
3 about a dozen different ways, and I just finally came
4 to the conclusion that it would be more honest and
5 clean to just simply exclude all multiple primaries
6 from cancer model-specific rates.

7 **DR. ZIEMER:** Jim?

8 **DR. MELIUS:** Yeah, I have a question and a
9 comment. One's just more out of curiosity, but when
10 you run into sort of the limits of Analytica 2 in doing
11 -- when you have such a complicated dose -- exposure
12 situation, what do you do if you can't...

13 **MR. HENSHAW:** I don't think --

14 **DR. MELIUS:** I mean does it just slow it down
15 or is it a question of you're just -- it's just unable
16 to handle that...

17 **MR. HENSHAW:** The awareness of the problem
18 occurred when we discovered we had claims in the hopper
19 with rows that exceeded IREP's capacity. We have not -
20 - we have not gotten to those yet in the dose
21 reconstruction.

22 **DR. MELIUS:** Okay, so it's not -- hopefully
23 you'll have the Analytic 3 that --

24 **DR. ZIEMER:** You have a comment?

25 **DR. MELIUS:** Yeah, my comment is related to

1 the issue of your review of the occupational studies
2 and the other issue that you're not dealing with,
3 though, I think it might be possible to -- at least you
4 should consider in that is this question of interaction
5 with other occupational exposures. If you're going to
6 be doing anything as part of that -- part of the work
7 that you are doing with the occupational health studies
8 I think sort of cataloguing what information might be
9 available and thinking -- it's just going to be hard to
10 separate out the two issues entirely, and I just --
11 rather than saying you're ignoring it, I think that
12 you're really -- I would hope that you're sort of
13 subsuming it under the other -- other issue because
14 there are -- particularly as we're dealing with IREP,
15 there are ways -- different ways of thinking about the
16 other occupational exposures, for example, that add
17 more uncertainty to -- to your -- the model and so
18 forth.

19 **MR. HENSHAW:** To be honest -- well, I think
20 that's a good point and when we get to the point where
21 we can begin a study of occupational -- a review of
22 occupational studies, which we intend to have the
23 literature review this year, the feasibility study, I
24 think that's a good point. I think we can try to look
25 at that, as well, to the extent that it's feasible to

1 do that, but I agree with you.

2 **DR. ZIEMER:** Henry and then Gen.

3 **DR. ANDERSON:** Just one thought that I had
4 that would be an interesting, difficult to interpret
5 analysis, but not unlike some you have here, would be
6 to look at the overall distribution of the types of
7 cancers you have, almost to a proportional ratio like
8 you do a proportional mortality and look to see is the
9 distribution, if you age-adjust it, is the distribution
10 of cancers in those that you have here different than
11 you'd expect in the general population or does there
12 seem to be more lung cancers, fewer, is liver
13 disproportionately represented in this group. I think
14 that would be -- treating this as a selective cohort
15 coming through, would be interesting to see. Are
16 claims -- are, you know, people putting in claims
17 because they believe a specific cancer is radiation-
18 related, or is it just every cancer that's occurred,
19 somebody has filed. I mean I think that would be
20 interesting to see, as their -- prostate looked to me
21 to be about right, the breast cancer's -- if you look
22 at, you know, incidence not mortality -- probably is
23 not out of line for the age groups here. But some of
24 them seem to be a little bit more than you might
25 expect.

1 **MR. HENSHAW:** I absolutely agree, and I
2 intend to do that. There will be some obstacles to
3 overcome as we do that. You know, what do you compare
4 it to -- you know, this data -- which block of this
5 data. You know, the way this data is modeled is not
6 the same as the way the data's modeled in NIOSH-IREP
7 and so on, but I agree, it's a -- it's a rich dataset
8 to look at from that point of view and I definitely
9 intend to do it.

10 **DR. ZIEMER:** I must have missed something
11 there. Henry, it's not clear to me what it -- what are
12 you suggesting be compared in that case, because these
13 are all -- I mean this is not a normal population to
14 start with.

15 **DR. ANDERSON:** Right, but what you do is you
16 have 1,000 people or 1,000 cancers --

17 **DR. ZIEMER:** Right.

18 **DR. ANDERSON:** -- and you say seven percent
19 of those were liver cancers --

20 **DR. ZIEMER:** Oh, the relative numbers of each
21 one --

22 **DR. ANDERSON:** Right, and then you look at
23 the general population where -- and age-standardize and
24 say in the general population it's two percent.

25 **DR. ZIEMER:** I gotcha.

1 **DR. ANDERSON:** And therefore you may -- and
2 then, one, looking at compensation, you may say gee,
3 there seems to be an excess of a cancer that isn't
4 compensated at all in this group. That would give you
5 some leads to look into some of the epi studies to see
6 -- 'cause these are all pretty well vetted for what
7 type of cancer it is, other than those that are
8 unknown.

9 **DR. ZIEMER:** Of course the underlying
10 question then is is a population group of cancer
11 individuals have this a priori -- should it have the
12 same distribution?

13 **DR. ANDERSON:** Well, I mean that's -- that's
14 part of the discussion of it, but at least you might
15 look to see --

16 **DR. ZIEMER:** A starting point.

17 **DR. ANDERSON:** It's a starting point to see
18 whether there are some of these. You would expect to
19 see in this population the radiation-sensitive cancers
20 ought to be over-represented.

21 **DR. ZIEMER:** Right.

22 **DR. ANDERSON:** And those that aren't, ought
23 not to be.

24 **DR. ZIEMER:** Right.

25 **DR. ANDERSON:** Now if those are rare

1 malignancies, then percentage-wise it isn't going to be
2 very easy to see early on, but I think that's what
3 you'd like to look at -- more for the consistency in
4 this database with what you know in the epi studies
5 rather than get into quantitative measures.

6 **DR. ZIEMER:** Dr. Roessler?

7 **DR. ROESSLER:** This discussion in the last
8 part of your presentation bothers me because even
9 though you have qualified the interpretation, many
10 times numbers like this are carried forward without the
11 qualifications and I think, other than scientific
12 curiosity, this really doesn't mean much at this point
13 and we ought not make too much of it. As you've said,
14 the small database, the efficiency process has
15 certainly made this a very -- not representative
16 population, even of the workers. And as I looked at
17 one of your slides where you presented the numbers with
18 regard to age, I keep wondering if because this is a
19 claimant-friendly process, that's just the normal
20 incidence of cancers with age and has nothing to do
21 with the radiation exposure. My point is, let's not
22 make -- have to be careful not to make too much of the
23 interpretations at this point.

24 **MR. HENSHAW:** Your point is well taken. I
25 mean absolutely. Hopefully no one will run up -- run

1 off and try to use this to affect regulatory decisions
2 or anything.

3 **DR. ZIEMER:** Okay. Other comments or
4 questions?

5 (No responses)

6 **DR. ZIEMER:** Thank you again, Russ. We
7 appreciate your input to us.

8 We are actually approximately an hour behind
9 schedule. At the beginning of the meeting I indicated
10 that we might have the opportunity for public comment
11 if we were ahead of schedule. What I will ask is if
12 there are any who signed up for public comment who
13 would find it very inconvenient to do their comments
14 this evening, which is the scheduled time -- if for
15 whatever reason, we can certainly accommodate -- yes,
16 are you on the list, sir?

17 **UNIDENTIFIED:** (Off microphone) Yeah.

18 **DR. ZIEMER:** If you prefer to give your
19 comment now, we'll be glad to hear --

20 **UNIDENTIFIED:** (Off microphone) (Inaudible)

21 **DR. ZIEMER:** Use the mike, please, and
22 identify yourself for the record.

23 **MR. COLEMAN:** I'm Thad Coleman. I worked at
24 PRTR for four or five years. That was a plutonium test
25 recycle reactor, a very hot place. Numerous times --

1 let's say you're a supervisor of a building. You have
2 50 or 60 pipe fitters (Inaudible) work with one welder.
3 Only one welder has the qualifications to go in and do
4 the welding. Well, how many of those pipe fitters you
5 going to burn out before the welder's burned out in the
6 same place? And whenever you do burn out, the
7 supervisor would come in -- give me your badge and
8 pencil; he took them and went and got me another set,
9 go back in. Well, after I took all I could, I got sick
10 and went home.

11 Well, they come out to my house to see if I
12 couldn't come back. They needed the welding done.
13 Well, with one welder, there was no way they were going
14 to get it done. But I had to go back in and do the
15 welding. I was overexposed many, many times.

16 Another thing they did there melting lead
17 with an acetylene torch, making shields. Well, lead
18 is very bad. We couldn't do it in the shop 'cause it
19 would contaminate the whole shop. They moved me
20 outside. You still had to melt it with -- I said why
21 don't you buy me a ventilator, a up-sucker to pull
22 these fumes away? Oh, it costs too much. I said I'll
23 tell you, I'll pay for it, you put it in. They
24 wouldn't do it.

25 Today my lungs are full and I'd like to get

1 somebody to tell me what is in there. Is it lead
2 poisoning, zinc poisoning, (Inaudible), brass poisoning
3 or what is it? They can't tell me. They say you've
4 got asbestosis. Well, that's one they don't pay. I
5 would like to have them prove that mine is not -- what
6 it is, because they can't -- I welded around the fumes
7 and the lead-based paint and stuff for over 60 years.
8 You get a lot of fumes in that much time. Yes, I had
9 asbestosis 'cause I spent seven years and eight months
10 in the south Pacific aboard ship a lot of times working
11 around (Inaudible), but it wasn't this asbestos
12 (Inaudible). My lungs are not asbestos today. I've
13 got something wrong. What is it? Can you tell me?

14 I got a letter from a little gal said your
15 statute of limitations expired, you don't qualify.
16 That's a very poor excuse, if you ask me. I took it
17 over to my doctor this morning and told him -- I had an
18 appointment at 12:30, 12:15. I said Doctor, I just
19 don't agree with this letter. But how are you going to
20 overcome it? What can we do about it?

21 Medicare gets a bill and it costs me \$449 a
22 month for my secondary insurance. Medicare won't pay
23 it. My insurance won't pay it. Well, then I got to
24 pay the damned bill. We need somebody -- a coordinator
25 in here to try to get this -- justice done. I know

1 this is important to do all this, but it costs a lot of
2 money. We're suffering like hell trying to get -- stay
3 alive, and sometimes I can't even talk, but you can't
4 even get a doctor to go in -- I got one doctor that I
5 think the world and all of him. He's Dr. Clipper and
6 he's helping me a lot. But I -- I just choke up too
7 bad to talk.

8 I would like to have somebody to tell me what
9 is in there. My lungs -- they said oh, your lungs are
10 gone. Well, now my teeth's gone. I just had them
11 pulled out day before yesterday. Is there any place
12 you could send me or tell me where I could go to get
13 somebody that could give me an answer?

14 **DR. ZIEMER:** This Board probably can't answer
15 your question, but maybe -- maybe some of the staff can
16 direct you to who you should be in contact with. It
17 appears to me that this is -- is this one of the
18 workmen's compensation area ones that's --

19 **MR. COLEMAN:** Well, I don't know -- workmen's
20 compensation, what is that, money?

21 **DR. ZIEMER:** Well --

22 **MR. COLEMAN:** I told them I don't want to be
23 the richest man in the graveyard whenever I die.

24 **DR. ZIEMER:** I doubt if you will under
25 workmen's comp, but let's -- let's find out and maybe

1 after the meeting find out if there's someone here --
2 certainly a doctor's diagnosis becomes a part of this,
3 and then I don't know where in the system we plug this
4 gentleman in, but we'll see if we can find somebody to
5 at least assist you.

6 **MR. COLEMAN:** I would just like to get to
7 where I can get my breath and breathe.

8 **DR. ZIEMER:** Yeah. Thank you.

9 **MR. COLEMAN:** That's all I'm after.

10 **DR. ZIEMER:** Okay. Appreciate your comments.

11 **MR. COLEMAN:** And the first thing they give
12 me, they say fill out another form. Well, hell, I've
13 filled out 50 of them.

14 **DR. ZIEMER:** Right.

15 **MR. COLEMAN:** And they look at me -- how many
16 cigarettes you smoke a day? I never smoked a cigarette
17 in my life. How much alcohol do you consume a day? I
18 never used a drop of it. I was a healthy, very strong-
19 willed man.

20 **DR. ZIEMER:** Okay.

21 **MR. COLEMAN:** And I thank God because I'm the
22 only one left out of my whole group that I worked with
23 a few years ago, and I'm the only boy that's left out
24 of ten kids, one girl. No, all I need is somebody that
25 knows what to do to get my breath.

1 **DR. ZIEMER:** Okay. Thank you.

2 **MR. COLEMAN:** Thank you for listening to me.

3 **DR. ZIEMER:** Are there any others that prefer
4 to speak now?

5 (No responses)

6 **DR. ZIEMER:** It appears not. Fine, then we
7 will recess until 7:00 this evening. We will reconvene
8 in this room and all are welcome to join us at that
9 time. This will be exclusively a public comment
10 period. Thank you very much.

11 (Whereupon, a recess was taken.)

12 **INTRODUCTION**

13 **DR. ZIEMER:** Good evening, everyone. I'd
14 like to ask you to please take your seats. We'd like
15 to get underway right away.

16 Thank you all for coming tonight. This is
17 the public comment session for the Advisory Board on
18 Radiation and Worker Health. My name is Paul Ziemer.
19 I serve as the Chairman of the Advisory Board, and the
20 Board is very pleased to be here in the Richland-
21 Hanford area tonight for this particular meeting.

22 Our meetings have very specific focus, but we
23 always have an opportunity for public comment, an
24 opportunity to learn about what's going on with respect
25 to individual people as far as it impacts on this

1 program.

2 Before we have the actual opportunity for
3 many of you to speak, I thought it might be of use if I
4 took just a few minutes and familiarize you with the
5 responsibilities of this particular Board. Our
6 responsibilities are quite well-defined, and to some
7 extent they are limiting in terms of what we are able
8 to do as a Board. And I want to make you aware of what
9 it is we do, and you can put that in the context of the
10 larger program that many of you are already familiar
11 with.

12 The program -- the workers compensation
13 program that we're talking about here tonight is
14 actually administered by several different entities --
15 the U.S. Department of Labor, U.S. Department of Health
16 and Human Services, the Department -- Energy Department
17 and also the Attorney General. So these various
18 Secretaries of the various Departments, all of their
19 agencies have a role in this process.

20 Independent of those agencies is this Board,
21 called the Advisory Board on Radiation and Worker
22 Health. The individuals on this Board largely are
23 independent of those agencies. I say largely because
24 actually some of the members of the Board may work for
25 one of the subsets of an agency. That is, we have some

1 individuals here who are associated with some
2 Department of Energy facilities. But in terms of our
3 day-to-day responsibilities, we are independent of the
4 program and serve as an oversight type of agency or
5 really board. And I want to familiarize you with our
6 responsibilities.

7 First of all, the Board itself -- its
8 composition is defined by law. It's -- the law
9 specifies that the Board will be comprised of up to 20
10 individuals. These individuals, incidentally, are
11 appointed by the White House, by President Bush, and
12 the White House actually determines the number because
13 they make the appointments, so there are not actually
14 20 individuals, as you will see. There are a dozen of
15 us at the moment. The White House also designates the
16 Chair of the committee.

17 And the other specification in the law is
18 that the individuals on this Board are to represent
19 certain facets of the interested community as far as
20 this law is concerned. And by that I'm talking about
21 labor, I'm talking about medical, I'm talking about
22 radiation safety or health physics types of
23 individuals. So there are technical, medical, labor
24 individuals. The individuals do not necessarily
25 represent specific groups, but have that kind of

1 background so they can bring to the table the
2 perspective of say labor or medicine or the technical
3 community.

4 These are the members of the Board. As I
5 indicated, I serve as Chair. We have a designated
6 Federal official, Larry Elliott, and Larry, as I
7 introduce each of you -- even though they have
8 placards, you might not be able to see the placards.
9 So Larry Elliott serves as the Executive Secretary and
10 also heads up the dose reconstruction program or the
11 Office of Compensation Analysis for NIOSH, which is, as
12 you know, part of the Department of Health and Human
13 Services.

14 Then we have Henry Anderson. Henry is not
15 back from dinner yet, so -- should not have gone
16 alphabetically, I guess.

17 Tony Andrade, who is with Los Alamos National
18 Laboratory; Dr. Roy DeHart, Vanderbilt University;
19 Richard Espinosa, Los Alamos -- you'll see in each case
20 an indication of their particular background. Mike
21 Gibson with Babcock & Wilcox; Mark Griffon has his own
22 consulting firm; James Melius, New York State Labor's
23 Health and Safety Trust Fund -- Dr. Melius; Wanda Munn,
24 who's retired but here -- one of your local people from
25 here in Richland; Charles Owens from U.S. Enrichment

1 Corporation, Paducah, Kentucky; Robert Presley is
2 actually retired, but is still there in Oak Ridge --
3 retired and working again, so to speak; and Dr. Gen
4 Roessler is retired from the University of Florida and
5 now living in Minnesota -- in Lake Wobegone, is it?
6 Yes, right.

7 The role of this Board is -- as I suggested,
8 is specified and it's pretty well-defined. We have a
9 role in the development of guidelines on the
10 probability of causation. That's that calculation for
11 the likelihood of a cancer or health effect being
12 produced by radiation exposure. We have a role in the
13 development of the guidelines for the dose
14 reconstruction process, so the first two bullets simply
15 summarize those responsibilities for reviewing the
16 guidelines as they're developed, and those guidelines
17 have been developed and the Board has, in a sense, done
18 those.

19 We have an ongoing responsibility to assess
20 the scientific validity and quality of the dose
21 reconstructions that are being done. This is an
22 ongoing process and the Board is underway and actually
23 has its own contractor now to assist in this process.

24 And then there's a role for evaluating and
25 assessing both guidelines and petitions that have to do

1 with what is called the Special Exposure Cohort. This
2 is a rulemaking which is still in process and the Board
3 has played an ongoing role in that process, as well.

4 So basically what you see here on this slide
5 are the responsibilities of this Board.

6 The Board does not deal specifically with
7 individual cases. We are not a Board that listens to
8 appeals or even reviews individual cases. We may, as
9 part of the determination of scientific validity and
10 quality of dose reconstructions, we may as part of our
11 audit process, look at specific dose reconstructions
12 that have been done to assess -- and in fact we will be
13 sampling a certain fraction of the work that is done by
14 the Federal agency, by NIOSH, to determine the quality
15 of that work. But we ourselves do not -- if you are a
16 claimant, this Board will not be specifically reviewing
17 necessarily your particular claim. And in fact, if you
18 have claim issues, they would be referred to the agency
19 that is responsible for processing that claim.

20 That completes those slides. I want to,
21 before we start the public comment, just make a couple
22 of additional observations. And that is that the
23 comment period, as far as the Board is concerned, is
24 really simply intended for us to hear from you. We're
25 not operating in a mode -- sort of a question and

1 answer mode because we -- we do not have access to your
2 specific case. Those, you know, are confidential. And
3 so we are not in a position tonight to answer specific
4 questions you might have. However, if you have a
5 question on your case, if you have a particular
6 question or concern, we certainly will make sure that
7 it gets addressed by the agency, whether it's NIOSH or
8 Labor or DOE, or make sure that we get you in touch
9 with the right person to do that.

10 We are interested in learning about how
11 effective this program is or where it is not effective.
12 We're interested in hearing whatever your experiences
13 may be that you're welcome to share whatever you wish
14 with us because that helps us get a feel for how this
15 program is working. So we do listen to a lot of
16 personal experiences. Not that we can necessarily
17 address them ourselves as a Board, but they do help us
18 in the context of trying to assure that the Federal
19 agencies involved do correctly and rapidly -- although
20 the speed is not always where one would desire, but at
21 least to be moving along on addressing the issues that
22 individuals might have. So any commenters are free to
23 talk about both their personal experiences as they
24 wish, but please understand that we're somewhat limited
25 as a Board in how we can deal with you on an individual

1 basis. But we do want to hear your stories and
2 experiences, and please -- if you have issues, we will
3 try to help make sure that they get addressed, even
4 though we may not be able to, as a Board, address them
5 individually with you.

6 **PUBLIC COMMENT**

7 Now with those preliminary comments, I have
8 already a list of individuals who have requested to
9 speak. And I think because of the size of the room and
10 the configuration -- although we have already set up a
11 mike near the back, I think it would be better if those
12 who wish to address the group would come up here to the
13 podium where you can be seen better. And also if
14 you're a little nervous, it gives you something to lean
15 on, so that always helps, too.

16 Oh, I do need to announce two things. One is
17 that for our public record we do like to have a record
18 of all who are in attendance, so there's a sign-up
19 sheet if you haven't already done this. It's in the
20 back and Cori, who's waving her hand back there, is the
21 keeper of the records and she will point you to the
22 right place to record your attendance with us tonight.
23 And then if you have -- if you do wish to speak and
24 haven't already done so, we ask that you sign up there.
25 And this just helps us keep the flow going and make

1 sure that we get everyone who wishes to speak.

2 So I'm going to return to my seat now and
3 I'll get the record there and we'll get underway. And
4 please excuse me if I don't pronounce the names right.
5 I can feel for you, mine gets pronounced incorrectly at
6 least half the time, also. It looks like Gai Oglesbee.
7 Is Gai here? Gai's with National Nuclear Victims for
8 Justice from here in Richland. Gai, could you -- would
9 you be willing to use the mike near the front so we
10 can...

11 **MS. OGLESBEE:** (Off microphone) Oh, okay.
12 That one up there?

13 **DR. ZIEMER:** Yes, please.

14 **MS. OGLESBEE:** Okay. I'm from this area and
15 I work with a lot of people across the nation to try to
16 help all I can because I am very experienced and
17 knowledgeable by now after many decades. My own
18 daughter is a claimant, as well, who suffers with
19 beryllium exposure and the effects of cancer, so it's
20 pretty disheartening sometimes, so -- I've had cancer
21 and her father has had cancer. We all worked at
22 Hanford. There's nine people in my family that have --
23 are battling with cancer right now.

24 Before I get started -- this is always a
25 show-stopper because you can't see it -- I know you

1 can't, but this is what radiation exposure looks like,
2 people. And I'll give your Chair a copy of it. A
3 friend of mine did this after traveling to -- they're
4 Russian farmers is what they are, by the Caspian Sea.
5 And I know people that have mutations just like this in
6 this country.

7 Then this is -- I want to get this in, too,
8 and again I'll give your Chair a copy. This is
9 (Inaudible) that was found on Hanford by individuals
10 appointed by the CDC that says dose reconstruction
11 cannot be done here at Hanford. That is very emphatic
12 information that's not being paid attention to.

13 Then there is a survey done already of
14 Hanford that lists what some of the construction
15 workers and people are exposed to at Hanford. So there
16 has been a survey done here -- many of them -- and I
17 have copies of them if -- and I'll probably try to send
18 them along.

19 So let me begin here by saying in my case the
20 agency employees are traditional agency defendants with
21 conflicts of interest with a point of view that is so
22 confrontational I have decided the incidents and
23 quarrels must stop. I didn't enter this to be put-upon
24 and I've -- it's cost me a lot of money to get where
25 I'm at right now in time and energy and my own

1 finances, and I live on a fixed income. So I was an
2 unmonitored employee, especially after I disclosed the
3 events that happened to me at Hanford B plant
4 (Inaudible). There are many in this room who know my
5 story. I support them and they support me.

6 Because the escalation of my historical
7 issues a high-ranking government official, the former
8 Secretary of Energy, Hazel Leary (sic), came to
9 (Inaudible) by April 17th, 1996, which was indeed her
10 obligation anyway, and she knew that. Secretary Leary
11 (sic) decisively enforced her initiatives.

12 Consequently, her subordinates were disciplined for
13 their adversarial role against me. Because of this
14 error of adjustment, I processed through -- there is a
15 contract -- I -- as I processed through, I should say,
16 there is a contract in place that forbids the Hanford
17 contractors and the USDOE from violating the terms of
18 agreement. If one agreement's violated, the rest are
19 still intact, so this became a problem for me with some
20 of the agencies and agents that I had done business
21 with before in my past.

22 In a private meeting before I testified
23 before the USDOE Assistant Secretary Environmental
24 Health and Safety, which was Dr. David Michaels, I was
25 encouraged to apply for EEOICPA provisions after being

1 informed that my history would not affect my right to
2 apply. USDOE contractor Oak Ridge Associated
3 Universities disqualified themselves already due to
4 their recognition of conflicts of interest about a year
5 and a half ago. The USHHS subsidiary, CDC-NIOSH,
6 employees seem to be unable to get a grasp on the
7 concept of conflicts of interest where I'm concerned.

8 Because of my background, knowledge and
9 experiences, I know for a fact that health physicist
10 evaluations are not considered expert in any illegal
11 (sic) adjudication process I am aware of. My expert
12 witness is a high-profile Ph.D. peer who heads a team
13 of ten international experts. The preparation of my
14 expert witness evidence cost \$24,000, and that was done
15 several years ago.

16 NIOSH insists that the expert witness do not
17 outrank their scientists and methodology. Well,
18 perhaps the time will finally come when we test the
19 NIOSH employees and the USDOAC employees -- employee
20 Admiral Rollow's perspectives in Federal court.
21 Consequently, for lack of better -- a better phrase
22 that is powerful enough to -- definition enough to use,
23 Dr. John Howard, Director of NIOSH, and I are in a
24 pissing contest -- excuse me, but that's what it is --
25 regarding what he feels in his right -- is his right to

1 dismiss my generic dose reconstruction. I am informed
2 that the only evidence NIOSH would accept is imaginary
3 USDOE contractor HEHF X-rays. Obviously I have failed
4 to explain historical circumstances over and over again
5 to the NIOSH agents. I should not have to explain in
6 the manner that these agents have required. I am
7 wholly aware that I am not finished with my medical
8 monitoring, as that is an ongoing reality that I must
9 manage for the rest of my life, but Dr. Howard insists
10 that I shall obey his agency code command and sign his
11 waiver, or else.

12 The Interactive Radio-Epidemiologic Program,
13 IREP, that was created by Dr. F. Owen Hoffman, is
14 challenged as an unreliable methodology. The generic
15 causation has already been deemed unreliable for
16 individual causation purpose by peers -- peer experts
17 and also by the Ninth Circuit Court of Appeals, who
18 explain in their decision that Dr. Hoffman's theory is
19 not all that is needed to reconstruct the dose of
20 radiation-exposed workers and vic-- or victims,
21 whatever you want to call them.

22 My point is, because I am the only person in
23 the world who can release any of my original personnel
24 records regarding my case issues, I cannot be
25 absolutely sure that the records that are being

1 processed by the agency employees are the same records
2 I submitted. It appears NIOSH and USDOE employees are
3 relying on slush files -- what's been deemed slush
4 files provided by unassuming USDOE record-keepers. The
5 \$500 box of records I compiled have been lost,
6 rediscovered, lost, rediscovered, recopied, re-
7 established, lost again and rediscovered in the USDOE
8 mail room, according to the witnesses. Because of this
9 rhetoric, the originals I submitted in early August,
10 2001 were ordered returned to me, so I have the
11 original copies of what I originally sent.

12 I have custody of high-profile expert witness
13 testimony. That is a court record which is included in
14 my files I released for this EEOIC purpose. The
15 experts verify that I am irreparably damaged by
16 ionizing radiation and components. I have filed a
17 claim with the USDOL and the USDOE. This was
18 originally supposed to be presented to just the
19 Advisory Board, these quotes. I'm very alarmed by some
20 of them. Resigned -- this is Secretary Robert Card
21 testimony that was sworn before the Senate committee
22 March 30th, 2004. In that -- in a quote that was very
23 alarming to many of the survivors, the quote said
24 additionally given, the medical benefits are available
25 in most state workers compensation systems for living

1 applicants. We are moving applications filed by living
2 applicants ahead of those filed by survivors. Finally
3 given that the statute requires us to provide all
4 available information, including a dose reconstruction
5 from relevant Part B applications, we are setting aside
6 these Part D applications where Part B dose
7 reconstructions are pending.

8 Now Senator Grassley, as you know, is very
9 heavy into this situation. And I also have made some
10 quotes because I was challenged today by Mr. -- or
11 Admiral Rollow, and I want to read -- these aren't my
12 statements -- sworn statements. These are Senator
13 Grassley's sworn statements. It says (Reading) Nothing
14 can make up for the illnesses these workers developed
15 because they were exposed to toxic substances without
16 their knowledge or consent.

17 That's me. Today they wear their battle
18 scars in the form of illnesses and disease and --
19 diseases, the least of our -- our government can do is
20 try to compensate them, compensate them quickly and
21 compensate them before they die, but that -- but that
22 is a problem. The program is moving like molasses.
23 Thousands of workers or their survivors are in limbo
24 while their requests for help sit in offices here in
25 Washington. We need reform with -- with accountability

1 and results.

2 Now he goes on to talk about the Science and
3 Engineering Associates known as SEA, which is a USDOE
4 contractor. This company's employees are the ones
5 processing the compensation claims of sick workers.
6 What we found should make Congress think twice before
7 forking over more money to the Energy Department,
8 especially without any guarantees that things will get
9 better. Mr. Chairman, I want to note that the Navy and
10 SEA don't want these numbers to come out. They stamp
11 the words business confidential and priority in big red
12 letters all over their invoices. Sometimes people in
13 government contractors who feed from Uncle Sam's trough
14 forget who they are working for. They're working for
15 the taxpayers, not themselves, and they should not be
16 trying to hide the way they're using taxpayer money.

17 The Energy Department's seeking \$33 million
18 in FY '04 appropriations transfer, plus \$43 million for
19 its FY '05 request, totaling \$73.3 million or \$77
20 million. The Department of Energy's plan to eliminate
21 the entire backlog of applications will be 2006,
22 commonly referred to as a path forward plan.

23 Let's see -- SEA is charging exorbitant
24 amounts of money for questionable results. An aide
25 position at SEA bills the government at a rate of 36.9

1 or \$36.09 an hour that comes up to \$72,180 a year.
2 That's a lot of money for someone who makes copies,
3 sends FAXes and puts files in filing cabinets. Then
4 they get their 40 percent an hour benefits. And people
5 who do the bulk of the case preparation work at SEA are
6 the nurses who examine compensation claims and get them
7 ready for the physicians and make a decision. Now how
8 is it that when I have an expert witness and a ten-team
9 international team of witnesses that a nurse -- and I
10 don't really -- I don't want to offend the nursing
11 profession, but I don't see where that is a reliable
12 source. Sorry, they don't know what we know and what
13 anybody else knows, but that's the way it works. And
14 they're making \$90.51 an hour for nurses' work and
15 about \$181,000 a year. The highest-paid SEA official
16 on the project is Richard Cutshaw, the program manager.
17 SEA is billing \$264 an hour for the -- his time. Let
18 me be clear so there's no confusion. I said \$264 (sic)
19 cents per hour. That comes up to \$401 -- \$200 --
20 \$401,280 a year. Mr. Cutshaw costs the taxpayer more
21 than the salaries of Energy Secretary Abraham and Labor
22 Secretary combined. He costs more money than the Vice
23 President, and SEA charges just a bit more for his work
24 than the salary of George -- President George W. Bush.
25 Mr. Cutshaw's counterpart at the Labor Department would

1 be a GS 14 director or district director who costs
2 about \$135,000, including fringes. Only in the
3 government contract can people make so much money and
4 perform so poorly. If this were the private sector,
5 these people would not be -- would get canned and be
6 out on the street. Now we know how much the Labor
7 Department folks are getting paid. We don't know how
8 much SEA employees are getting paid. We only know how
9 much the company is billing the taxpayers for their
10 work.

11 And in excerpt quotes, USDOE Admiral Rollow
12 explains that I have misunderstood all the issues and
13 that if I repeat any of the conversation we had this
14 afternoon that I can be charged with slander. I would
15 say, Admiral Rollow, that you don't know where I've
16 been or what's going on and you need to find out
17 because your -- your people are handling my case right
18 now, and you assured me that they were.

19 Can Admiral Rollow handle a job after making
20 a statement such as this? Is everybody wrong and
21 Admiral Rollow right? It is Senator Grassley's sworn
22 statement and other of his associates investigative
23 findings, it wasn't mine. I have before me several
24 sworn statements regarding the conduct of the USD
25 employees that are before me to ponder. I'm not quite

1 ready to talk about those yet, but they're pretty
2 disturbing, I can tell you that, that involves me.

3 My daughter Carol is also an EEOICPA claimant
4 who battles with the health effects caused by cancer
5 and respiratory problems after being exposed to the
6 harmful toxins at Hanford and Rocky Flats. In 1993
7 Carol was notified by the USDOE she was exposed to
8 beryllium because a coworker died after developing the
9 disease. Gai Oglesbee, Subtitle B and D claimant,
10 National Nuclear Victims for Justice. And I will give
11 your Chair a copy of what I have here, and I have many
12 more -- any many more records I want to send you. I
13 have over 75,000 records accumulated.

14 **DR. ZIEMER:** Thank you very much. Our next
15 speaker will be Thad Coleman, and Thad -- oh, that's
16 the individual who -- I think Thad already addressed us
17 this morning -- or this afternoon. Thank you.

18 Louisa -- is it Jahnke? Louisa Jahnke.

19 **UNIDENTIFIED:** (Off microphone) (Inaudible)

20 **DR. ZIEMER:** I'm sorry?

21 **UNIDENTIFIED:** (Off microphone) (Inaudible)

22 **DR. ZIEMER:** You want to use this mike here?
23 Oh, okay. Thank you. Did you have someone else you
24 wanted to speak in your behalf or --

25 **UNIDENTIFIED:** (Off microphone) (Inaudible)

1 **DR. ZIEMER:** Okay, thank you. E. R. Samser,
2 Samson, Samser -- E. R. -- you might have to correct me
3 on the name, sir, when you get up there. He's from --
4 Samson from Kennewick.

5 **MR. SAMSON:** Well, there's quite a few people
6 here tonight I know, but anyway, I've worked around
7 here many a year and everything, but I'm not going to
8 talk about that.

9 I am so thrilled that this group that's here
10 now has give us more information in one day than we've
11 had in four years here. Now that's pretty pathetic,
12 really. That's the thing that's disturbing me.
13 They've got a lot of money they're spending and
14 nobody's telling us nothing. And I mean it's bad when
15 you call Seattle and they say well, can I get -- I want
16 to see where my list is of my -- on my plan that -- as
17 I wrote to you guys about, and they say well, we'll
18 have to see if the examiner's got time to work with
19 you. I've seen the examiner one time in two months.
20 The rest of the time, he never comes on.

21 Here we are trying to find out what's going
22 on. I think I have a pretty good claim, you know. I
23 worked all over the -- every area out there and
24 everything. My nose is half gone and everything, but I
25 don't -- I don't let that bother me. What I want to do

1 is -- we got a little group of people here that a lot
2 of their husbands has all passed on and whatever, on a
3 fixed income. I want some of them people. I'm not
4 worried about me, I'll make it. But some of these
5 people that needs the money and everything, you know,
6 especially on the medical end of it. So I'm going to
7 close by just telling you that. I think we need some
8 more help like you give us today would help a bunch of
9 things around here. Catch you later.

10 **DR. ZIEMER:** Thank you for your comments.

11 (Applause)

12 **DR. ZIEMER:** Again, I'm having a little
13 trouble reading the writing. It's -- the last name
14 appears to be M-o-u. Is it -- could be a Charles W.
15 Moore, maybe?

16 **MR. MOORE:** (Off microphone) That's me.

17 **DR. ZIEMER:** Is it Moore?

18 **MR. MOORE:** (Off microphone) I'm not a Ph.D.
19 there and I wrote that.

20 **DR. ZIEMER:** Well, you must be a medical
21 doctor. It looks like a prescription to me.

22 **MR. MOORE:** (Off microphone) No, I'm not
23 (Inaudible).

24 **DR. ZIEMER:** Anyway, it's Charles Moore then,
25 is it, from Yakima?

1 **MR. MOORE:** Correct, from Yakima. I worked
2 23 years on the Hanford project. After 23 years I was
3 fired because I have asbestosis. I've never received
4 any compensation whatsoever about that, but that's not
5 why I came here to talk to you. I come to talk about
6 reconstruction of the dosage, and I have a whole bunch
7 of documentation that I want to give the panel. I have
8 one here that's got my name on it. It's a five --
9 four-page document about my personal exposure, but it's
10 not what I come to talk to you about, nor will I read
11 it.

12 But I have a document here that I received
13 under public disclosure showing my dose rates from --
14 oh, boy, I had cataracts removed the other day and it
15 changed my eyesight a little bit -- from 1950 to 1972,
16 and it kind of lays out what I've received. And then I
17 went through my documentation and here's a document
18 here that says mine was withdrawn. Here's another
19 document that shows that I received a lot of radiation
20 in a year that is not on the first documentation. They
21 forgot to put it on there. And here's another document
22 exactly the same.

23 So I don't want to talk too long. I just
24 want to say that there is no way we can reconstruct
25 dose radiation from years ago because they didn't keep

1 track, nor did they give a damn -- excuse my
2 expression.

3 Here's another document from Battelle, says
4 that my documents has been changed, altered. This is
5 kind of one of my favorite ones. It says that I had
6 contamination on my nose in dash five building. I took
7 a shower, changed clothes, and I left the building and
8 the alarm went off. It wasn't on the tip of my nose; I
9 had alpha particles in my nose. That's kind of a good
10 example of what we had to contend with out there.

11 Here's another document that says that --
12 primary the same thing. It is not on the computer
13 sheet with the dates. Another document, deleted. And
14 here's a nice little document. Remember your weekly
15 radiation dosage that you signed the bottom of each
16 week? A lot of you remember those, don't you? Well,
17 this is not my signature. Somebody forged my signature
18 on this one. So how can we reconstruct something if
19 the left hand doesn't know what the right one's doing?

20 Here's another one about the same as the
21 other one. So I just wanted to give the panel these
22 documents to go through and look at and tell me if they
23 can figure dose radiation from what we received out
24 there. And I thank all of you, and have a good day.

25 (Applause)

1 **DR. ZIEMER:** Okay. Thank you, Charles. Next
2 we have Randy Knowles. Randy's with PACE and -- here
3 in Richland. Randy Knowles.

4 **MR. KNOWLES:** (Off microphone) I had intended
5 to speak on behalf of Mr. and Mrs. Williamson, but (on
6 microphone) their son's here and I think it's more
7 appropriate that you hear from him --

8 **DR. ZIEMER:** That would be fine.

9 **MR. KNOWLES:** -- instead of me.

10 **MR. WILLIAMSON:** My name's Jim Williamson. I
11 was just writing notes as I heard my name called, so
12 you have to understand I'm not really ready because I
13 didn't know I was going to speak tonight. But I'm
14 speaking on behalf of my mom and my family and my dad's
15 name was John Williamson and some of you know him as
16 Jack. He was hired in 1987 -- 1967 and he worked for
17 25 years. He retired in 1993, and that same year he
18 was diagnosed with cancer; 1996, a few years later, he
19 also had part of his nose cut off, like the gentleman
20 said earlier with him. And two years after that, he
21 was screened for asbestosis and it was confirmed he had
22 that. And in '99 he was diagnosed with myelodysplastic
23 syndrome and finally myelomonocytic leukemia in August
24 of '99. And I remember -- I mean I vividly remember --
25 I have four kids and I remember this day with my dad

1 more than I remember my kids being born, but I remember
2 the doctor looking at my dad and saying John, you have
3 a disease -- a rare disease that has no cure. You have
4 one year to live. I mean it was just a -- I replay
5 that many times in my life.

6 Again, here's where I'm not quite sure...
7 But anyway, my mom had LNI claim and it was from the
8 State of Washington and it was -- they won the claim
9 with the State of Washington and it was one of the few
10 or maybe the only ones with the Hanford cancer-related
11 cases that has won in the State of Washington, but in -
12 - for the Federal, for some reason, it's -- it's not
13 working, for some -- we just don't understand if -- if
14 it's one of those cases that the state is paying and
15 they're supposed to have some kind of process where the
16 cases that are -- that are easy to process and
17 everything's already done, and I -- and I don't even
18 know how many years ago it was, three, four years ago,
19 my mom's still trying to deal with this and it keeps
20 getting backed up or they call her and they're doing a
21 phone interview and my mom doesn't -- my mom's here so
22 I can't say anything bad about my mom, but she doesn't
23 have -- she doesn't have a clue on those kind of
24 questions or the way they're asking the questions. So
25 I teach school and I take off school and I go over and

1 I try to help my mom with the questions and it's just -
2 - it's kind of unfair -- it's very unfair, and I feel
3 for the -- all of you that are in here that are going
4 through that, that are dealing with this stretched out
5 and stretched out. Again, I -- I don't know what it
6 is, four years, five years -- seems like a long, long
7 time that we're dealing with this process.

8 So again, I just -- if it -- to me, if it
9 happened at the State of Washington and they've already
10 gone through and they say yes, it's -- he died of
11 cancer and I -- and then how come at the Federal level
12 it's -- I don't know, we need to check it out a little
13 bit longer and spend another four years. Anyway, it's
14 -- sorry for being unorganized, but I didn't know I was
15 going to be speaking tonight.

16 (Applause)

17 **DR. ZIEMER:** Okay. Thank you very much, Jim.
18 Next we have Ken Staley. Ken Staley, is it? Ken?

19 **MR. STALEY:** (Off microphone) Here or up in
20 front?

21 **DR. ZIEMER:** We'd prefer in the front, if
22 you're willing.

23 **MR. STALEY:** (Off microphone) (Inaudible).

24 I think maybe I'll talk into this. My name
25 is Ken Staley. I come back here in 1946. I come out

1 here in the '40's early when they were building
2 Hanford. Uncle Sam knocked on the door and I got hurt
3 in the south Pacific. I come back in '46 and started
4 working at Hanford and there isn't an area out there
5 that I haven't been in.

6 And I think probably that I've looked around
7 the room here and seen a lot of people that I know have
8 worked there, but it's very obvious to me that when we
9 first started working out there, you were allowed 300
10 millirems a week. You were allowed 50 a day or 300 a
11 week. My contention is, no one explained where that 50
12 went and you were able to pick it up the next Monday,
13 or the next -- the next week.

14 I understand from my son-in-law now they're
15 allowed only 100 a week. Am I getting to everybody?
16 Well, I'll tell you what. The people have moaned and
17 groaned about these down-winders. I happened to have
18 worked in that 108-B building, the P-10 project. I
19 have four children by my first marriage, '47, '49, '51
20 and the one born in '53. It so happens that not only
21 me, but my friend of mine's daughter was born the same
22 time in '53 that the down-winders are hollering about
23 this stuff that went up the stack, that beautiful
24 yellow smoke. She's been in a wheelchair over 30 years
25 with MS. Her girlfriend, born the same time, over the

1 same period of time, is in the ground. I have asked
2 several people, did I contribute that to them.

3 And this building, this 108-B building that
4 I'm talking about, this other electrician is in the
5 ground, and I went in there. I said Art, what in the
6 world have they got these scales in here for? Well, he
7 said, Boat, he -- my name is Boat, Steamboat. He said
8 they weigh this heavy air before they let it go. I
9 said what the hell they let it go for -- excuse the
10 French. Once in a while I speak French. He said but
11 they weigh it so they know how much they've got.

12 Now I know -- I go around the room and I know
13 a lot of these people go around 240 to shortcut over to
14 the coast. They see this beautiful orange-yellow smoke
15 go up the stacks in the 200 areas. What is it? I'll
16 tell you what it is -- contamination off the slugs that
17 they've taken the stuff off them. Where does it go?
18 Out in the prairie. Now they're worried about the deer
19 and the rest of them having it. Well, I wouldn't eat a
20 deer from out there anyway, but my contention is this.
21 This gentleman that's sitting back here that I worked
22 with for years, if you've noticed his beautiful nose --
23 1973 he had a speck go up his nose; it took them five
24 hours to get it out. They went in with chemotherapy
25 and burnt on him. It come back on the lobe about a

1 year later. If you look at his beautiful face, it's
2 going to cost \$40,000 to get it rebuilt. There hasn't
3 been one iota finances to help this gentleman out --
4 none -- whether the Medicare or the -- what will take
5 care of it, but they're not getting off their duff here
6 to help anybody that has been irradiated with this
7 stuff.

8 I've got beautiful arms here. It's not from
9 the sun. It's from different things that you get into
10 out there. I've never smoked in my life. I have to
11 admit I put them on -- swinging graveyard in the bars
12 once in a while. But security was so tight at the time
13 that this happened in the '50's and the early -- late
14 '40's that five of us had a glass of -- one pitcher of
15 beer down at the old Rec Hall down here, and I happened
16 to be the last one in. This is telling you how tight
17 security used to be. I was the last one in with this
18 little glass sitting there and I said gosh, that's for
19 saving it for me. You better be good 'cause we were
20 about to drink it. I sat down and said see those two
21 fellas sitting at the bar up there? I said yeah. He
22 said that one guy's been shooting his mouth off of what
23 he's been doing out there. And I hadn't finished that
24 glass of beer and he grabbed him bar and he said he's
25 fired, come on.

1 Now this is how tight security is and nobody
2 -- and I'm sure around here a lot of them know what I'm
3 talking about, but I know there's a woman didn't want
4 to get up here, used to be my neighbor, and we were
5 interviewed from the State Radiation Department, three
6 of us, Ray Samson, myself and Louise Jahnke. She has
7 pictures of her husband. For the last five years he
8 was dying of radiation poisoning. She don't want to
9 speak.

10 We were interviewed three years ago by
11 *Seattle Times* -- three years ago, Bobby Pittman, Ray
12 Samson and myself. Bobby Pittman had radiation so bad
13 when he come out of that danger zone, they field-
14 stripped him, scrubbed him and buried the truck. Now I
15 know a lot of you people working out there know what
16 I'm talking about, burying radiated equipment. Before
17 my friend Bobby Pittman died, he was on chemotherapy
18 three times a week. Now if you think that's fun, try
19 it.

20 I'm not going to get up here and preach
21 because I preach Fridays. I don't know religion
22 preaches Fridays, so I'm going to get down. But I do
23 want you people to know that they're very, very slow in
24 compensating these widows and some of these other
25 people out here, and it's very obvious that somebody is

1 filling their pocket up other than taking care of these
2 widows. I have a unit of about 12 or 20 people -- I
3 think it's real close to 20 people -- that we are
4 talking about, widows. I'm looking at a few of them
5 around here. What they're living on? I had one of the
6 people say -- I had to loan this woman \$100 so she
7 could eat for the rest of the month. Is that fair
8 because her husband died of this stuff? Not really,
9 fellas.

10 I've heard this early morning session where
11 they were talking about Paducah, this wave and -- I
12 think I heard, in the whole course this morning,
13 Hanford mentioned only twice. What are they waiting
14 for? These men and women come in here to understand
15 what kind of stuff has been going on out there, and
16 these people at NOSHA (sic) down there or whatever they
17 call it, I don't think any of them -- I don't believe
18 any of them have ever been across that 300 area line
19 toward the radiation and know what they want.

20 I have a claim number. I have been denied.
21 I had a sample taken out of my arms that are so
22 beautiful, but they took it in the wrong place. It
23 come back benign. My case number's 2398. I've heard
24 nothing but it has been denied. So it kind of makes
25 you wonder, and the woman down there was a little bit

1 impudent with me. I said don't worry about it, they
2 still make lawyers, and that's a heck of a way to be.

3 I'm not going to preach anymore because I
4 know there's other people got better stories than mine,
5 and I thank you.

6 **DR. ZIEMER:** Thank you, Ken.

7 (Applause)

8 **DR. ZIEMER:** Next I have Michael Henning. Is
9 it Michael Henning? Michael Henning is -- I think
10 that's Henning. Anyone with a name similar to that?
11 Okay, perhaps is not here.

12 Richard Miller, Government Accountability
13 Project.

14 **MR. MILLER:** (Off microphone) Why don't I
15 pass for now, Dr. Ziemer?

16 **DR. ZIEMER:** Okay. Donna Beecroft. Donna?

17 **MS. BEECROFT:** I wanted to make a comment on
18 dose reconstruction. In January of 1943 we moved here.
19 My dad was one of the first people to be a reactor
20 operator out at Hanford.

21 In those early years you probably know that
22 the rods -- the nuclear rods were changed by hand, so
23 whenever the reactor slammed, Dad would go in and put
24 on these white gloves and white suit and go in and take
25 these rods out and they were disposed of. The gloves

1 came off and went into a big bin and the white suit
2 went into a big bin, and all of the beautiful equipment
3 like pliers and wrenches also went into a bin and
4 everything was buried.

5 One time one of Dad's coworkers tried to
6 sneak a wrench home in his lunch box and was fired
7 immediately. And my dad was not a person ever to take
8 anything that didn't belong to him, but he thought that
9 was so severe because I don't think in those days they
10 understood anything that they were up against. This
11 was -- this was fun, it was wonderful, it was exciting
12 and we loved living here.

13 We didn't come and ask for this money. I was
14 approached and asked if we would apply for it, and I
15 feel like we have not been treated well and we never
16 asked for it. My dad worked -- when the reactors went
17 down, sometimes Dad worked three shifts in a row, and
18 they were -- they had a limit, and I don't know if it
19 was seven minutes or 12 that they were supposed to be
20 inside the reactor, and the -- but -- and then Dad
21 would come out -- seven minutes, and Dad would come out
22 and take off his gloves and his suit and put it in the
23 bin that gets thrown away and put on a new suit and new
24 gloves, and go back in again. And he wasn't supposed
25 to do that, but they did it over and over because when

1 that reactor went down, you didn't say well, my time is
2 up. You know, you kept on working, and they kept on
3 working and a shift -- back-to-back shift.

4 It's the first time Dad ever heard of a TV
5 dinner. They had these dinners and they'd just heat
6 them right up and it -- it was fun, it was exciting.
7 He liked it. And he didn't know that he was getting
8 sick, and some of his friends died. The first one was
9 Jack Spadey and another one was Earl Sealey, and I
10 happen to know them because -- I mean I knew them
11 personally, and so -- and I'm sure a lot of others did,
12 too.

13 Anyway, now when I -- I call, they tell me
14 well, we are looking at -- this is ten months -- ten
15 months Dad's been in dose reconstruction. We're in
16 dose reconstruction, but I'm wondering, you know, how
17 in the world are you doing dose reconstruction when Dr.
18 Charles Moore who spoke to you, his record's from 1950
19 to 1976, and do you think they did a better job in
20 record-keeping back in 1940? Let's see, 1943, that's
21 when Dad started working, before they even had robots
22 to change those rods. He was changing them with his
23 hands. And you say you're going to do -- Dad knew what
24 he was doing was illegal. He wasn't supposed to be
25 taking that -- he'd -- he'd go on the geiger counter,

1 it'd tick -- when it ticked so hard that he couldn't
2 make it quit ticking by showering and scrubbing and
3 soaping, when he didn't quit ticking, then he didn't go
4 back in anymore. But he came home like that.

5 Now I don't want you to think we're a pitiful
6 little family, because we're not. And we are proud of
7 what my dad did and we're proud of him. We're proud of
8 Hanford. We love it and we've enjoyed our lives here.
9 It cost us to be here, but it's worth it. But this
10 wasn't just Dad.

11 When he comes up with bladder cancer, he had
12 years of chemotherapy, changed his personality, it's
13 taken a toll. I have three brothers and all three of
14 them have thyroid problems and have had to have -- one
15 of them's had the thyroid removed, maybe two. My only
16 sister had breast cancer. My mom died of cancer. I
17 seem to be the only one who made it just great, but
18 anyway, the dose reconstruction, that's my point.

19 I don't think it's honest or fair to say
20 you're going to do dose reconstruction. You can't do
21 dose reconstruction. They didn't keep those records,
22 and you know they didn't write down when the dosimeter
23 had a higher number than was legal. They didn't write
24 that down. They wrote down something that was legal.
25 And why is it that DOE has recognized that it's

1 impossible to do dose reconstructions at other sites,
2 but not at Hanford? I don't think it's fair.

3 We didn't ask for the money. I was not -- I
4 was contacted. I didn't come and ask for it. But now
5 that it was offered, and it's been what, nearly three
6 years or -- over -- well, and -- and as far as I know,
7 there isn't anything's been done on it, and it seems
8 like it's a dead end. And I appreciate the opportunity
9 to speak to you.

10 (Applause)

11 **DR. ZIEMER:** Okay, did Michael Henning come
12 back to the room? Yes.

13 **MR. HENNING:** My name is Mike Henning. I've
14 worked out there since 1978 and --

15 **UNIDENTIFIED:** (Inaudible)

16 **MR. HENNING:** My name's Mike Henning. I've
17 worked out there since 1978. I've worked pretty much
18 every building that's there. I was working as a QC
19 inspector, inspecting pipes they broke and everything
20 else, and going in the tank farms and doing that sort
21 of stuff. And I have had my reconstruction done. I
22 filed it in 2001, December 2001, and they came back and
23 said that I had so many rem and that it was less than
24 the 50 percent required.

25 Well, they didn't say what the 50 percent

1 required was, where it had to be five rad or 50 rem or
2 whatever it was supposed to be. They didn't never tell
3 us -- tell me in the letter or anyplace else that I
4 know of what that criteria is. And where do they come
5 up with this criteria, pull it out of their hat? I
6 don't know. They don't tell you that, either, where
7 they got these criteria for making these -- for
8 rejecting you or whatever. And I -- I've had lymphoma
9 cancer five or six years ago -- six years ago, and it
10 hasn't come back again, but I don't know whether it
11 will.

12 You have people ask you whether or not you're
13 clear from the cancer. Well, I was clear before I got
14 it, so I don't know.

15 So I just -- I think they need to inform
16 people a little better about what criteria they're
17 using and where they got their criteria and give --
18 like I said, they said I didn't meet 50 percent. Well,
19 what was 50 percent? I don't know. So thank you very
20 much. Oh, and I am glad you guys are here.

21 (Applause)

22 **DR. ZIEMER:** Thank your very much. Your
23 comments are noted. The issue of communicating is one
24 that we hear fairly regularly and it's something that
25 is certainly being worked on.

1 Let me ask if there are any other individuals
2 here who did -- who did wish to speak but did not get
3 an opportunity to sign up on the sign-up sheet?
4 Sir? Please. We have a little time, so we
5 can take additional...
6 **UNIDENTIFIED:** (Off microphone) (Inaudible)
7 gentleman says he signed up and he hasn't been asked to
8 speak yet.
9 **DR. ZIEMER:** Am I missing a -- I may be
10 missing a sheet. Please go ahead, sir, and we'll -- we
11 have time, we'll get you next.
12 **UNIDENTIFIED:** Well, I want you to know I'm
13 only 86 years old. I came here to Hanford in 1944.
14 **DR. ZIEMER:** And give us your name, for the
15 record, please.
16 **MR. SHATELL:** Charles W. Shatell.
17 **DR. ZIEMER:** Thank you.
18 **MR. SHATELL:** And I came here with the DuPont
19 Company, but as far as radiation work is concerned, I
20 wasn't involved in any until 1948, and from 1948 I
21 worked for the Jones Company and -- or the contract
22 under Jones, and we did radiation work for all the
23 reactors. And so finally with -- well, I ended up with
24 cancer. And in 1978 we used 400 men -- 400 exposure --
25 radiation exposures of 400 men in 100-N when we were

1 changing all the valves out. And of course now
2 everybody thinks this film you've got on your badge was
3 -- tell you how much radiation you took, and that is
4 not so 'cause most of the times that we worked in 100-N
5 on all those valves, it was beams from material that
6 was in these valves. And a lot of -- well, I guess
7 that when the fuel elements had a rupture and then
8 those -- those partly -- is -- gets into the valves and
9 you get a beam from them, and that's what you get most
10 of your radiation from was the beams from ruptured fuel
11 elements and whatever. And I don't know how many times
12 I've talked to people since I've been in this cancer
13 business, and they think this film badge on here tells
14 you how much you get. Well, that's not so.

15 Well, anyhow, in 1978 we did all this work
16 out here at 100-N. And as I say, we used 400 -- the
17 exposure of 400 men. And right at the last of the
18 valves, we run into cobalt 60. I don't know whether --
19 how many of you know about cobalt 60 or not, but
20 anyhow, we had a rupture -- fuel element, evidently --
21 and we had a valve that read 550 R, which is pretty --
22 pretty rough. And that day that we run into this valve
23 that read 550 R, everybody left. And you couldn't
24 blame them. All the engineers and everybody that we --
25 was taking over the thing, they all left. They didn't

1 want anything to do with 550 R.

2 So we -- when we took the contract from Jones
3 to do these valves, we anticipated that we might run
4 into some high reading radiation, and so we built boxes
5 -- lead-lined boxes, even up to the point of three-
6 quarters of an inch thick of lead -- that when we cut a
7 valve out we could put it in that and then you could
8 handle it. But this cobalt 60 -- and I didn't know
9 that they was even using cobalt 60 as a fuel element,
10 but I guess they were. So we run into this valve that
11 was reading 550 R and so what do you do? You can't
12 even get close to it.

13 So the plumbers and the fitters are the ones
14 that had jurisdiction over these valves. We had
15 decided that we would take 300 MR per week. That was
16 it. And anybody caught going over that amount on their
17 own, like putting their things in their hip pocket or
18 whatever, they would get fined \$1,500, so most of them
19 -- nobody ever went over it that I know of.

20 And so I know that I was one of the -- I was
21 the general foreman over the group and any time we had
22 something that was reading 550 R, I wanted to be damned
23 sure that somebody didn't do something wrong, so I went
24 with them all the time whenever we had something that
25 was -- reading that hot. And so I happened to be -- I

1 happened to be one of the people that did one of the
2 operations that -- we decided how we were going to do
3 it and got it all set up to take this valve out. And
4 we got young -- agile young fellas. The boy that could
5 go by the valve and put a choker on it in three seconds
6 -- he had three seconds. In three seconds you would
7 get 300 MR. He had to do it in three seconds, so he
8 did it. And I know I was up above with a electric
9 hoist with a hook hanging down and he hooked the choker
10 onto the -- onto the electric hoist.

11 So anyhow, then the welder that cut the
12 bolts, he had a cut torch with a six-foot handle and he
13 was able to take his 300 in one minute, and he cut the
14 four bolts -- cut the nuts, the bolts off, then they
15 dropped out.

16 In the meantime, we had this valve hoisted
17 up, pulled the pipe apart and whatever and we hoisted
18 the thing up. And the job that I did was nothing. I
19 put a plastic bag over the valve as it come up through
20 the floor. And -- because if that particle that read
21 550 R dropped out on the floor, you'd been in a hell of
22 a shape, so that's what I did. And I put that -- that
23 plastic bag on the valve, and it come right up by me
24 and I had three seconds to do it, and I did it.

25 And so two years later, that's when I found

1 out when I had a four plus four cancer in my prostate,
2 and it was really -- I'd never had any cancer before or
3 anything like this. I've been a pretty healthy guy all
4 the way down the line, so anyhow, when this new
5 urologist come in, he got a bunch of new equipment and
6 he -- he found this -- with the biopsies, he found this
7 cancer on my prostate and it was four plus four. Now I
8 don't know whether -- how many of you know what four
9 plus four means. They told me that five plus five
10 would kill you, so it was -- pretty hot thing.

11 So anyhow, now I signed up for this deal for
12 the Hanford setup, and when I signed up for it of
13 course they needed all this information. The Jones
14 Company that I was -- worked with, every day that
15 anybody worked on any of our radiation, we had a log
16 book that was fixed up every day and wrote down exactly
17 what everybody did, how much radiation they took and
18 location and everything. The reason we did that was
19 because we got sued two or three times for people
20 saying they did this and did that -- just like your
21 down-winders or whatever now that stuff drops into you
22 out of the sky. But anyhow, those log books, when I
23 left there we had a whole filing cabinet full of them.
24 And Jones Company, when they left out there, they give
25 them to DOE and brought them down here to DOE. If they

1 could get those log books, that'd solve a lot of
2 problems for these people as to what they did, where
3 they did it and how much radiation they took and the
4 whole works. So -- but they tell me they can't find
5 them, so I don't know.

6 But anyhow, I signed up with this thing and
7 I've been going through all the -- the -- for the NIOSH
8 and the whole works, and in 2002 I spent \$10,000 on my
9 cancer. Now the shots that they gave me -- I know that
10 gal from DOE says what? The shot I took every four
11 months was \$2,400 a shot, and it didn't take too long
12 to get up to \$10,000 bucks when you do that. But it
13 did the work. It got my cancer way down, PSA was way
14 down. But I still got -- the doctor said oh, hell,
15 your PSA is down, you don't need any more shots. I
16 said no, I want a biopsy to make sure. So we had a
17 biopsy and find out sure enough, I still got a little
18 bit of cancer left. So we're thinking the \$2,400 shots
19 -- it was \$2,360 when we started but \$2,400 now, and
20 (Inaudible). I can't under-- this nurse says did you
21 ever have gold pumped into you, and I said no, I never
22 did. She said well, you just did. At that time the
23 shots was \$2,360.

24 So anyhow -- so now I've went through all
25 your NIOSH and I've went through telephone interviews

1 and I've went through the whole works, and finally I'm
2 back to the deal now where they want to know actually
3 how much money I spent, so maybe they're getting ready
4 to pay me, I don't know. But I asked that -- the girl
5 that is the first gal under -- oh, the head of the DOE
6 -- she wrote me a letter and told me about (Inaudible)
7 four plus four cancer, and she knew it was high, and
8 she put her phone number on there, so I figured if
9 anybody puts their phone number down, they expect you
10 to call them. So I did and I called her and I said
11 well, what I want to know is when are you going to
12 start paying us some money so we can get -- get this
13 thing back in shape again. And she said well, that's a
14 different story. She said we put in for that program
15 every month into the White House, and Mr. Bush turns
16 her down every time. He said they've got insurance,
17 let their insurance take care of it. Sure, I've got
18 insurance. But my insurance now is up to \$530 bucks a
19 month and it's going to go higher. You can bet your
20 life on it. And each time I get a letter from the
21 insurance company that says -- and they turn their --
22 turn me down, but they said we're taking it under
23 advisement. So finally they come and pay it. But with
24 \$530 a month, that's getting up around \$6,000 a year.
25 And so I think it's time that NIOSH or whoever's doing

1 it would be start recognizing the fact that the
2 insurance companies can't be expected to pay for the
3 whole thing.

4 And then another thing, that other \$40,000
5 that they had there was -- I don't know what that was
6 for, for a person. And every time I talk to anybody,
7 how's your cancer doing? So it -- that \$40,000 was to
8 take care of whatever happened to you, I suppose. But
9 I think -- I think that radiation, as far as Hanford
10 was concerned, we did a lot of it. And all the records
11 was kept and everything and I'll say one thing for the
12 DOE. When we had suggestions, they did them. We told
13 them how to clean the radiation down and before we'd go
14 in, and for a higher radiation they would clean the
15 place up first, and that was good. And they got us
16 blankets with -- lead-lined blankets to where we could
17 stop these -- the beams from hitting you. So I'll say
18 one thing for them, they were -- they were cooperative
19 with us on the thing.

20 But since you have a group here of these
21 people, I think there's one thing I would -- I'd just
22 like to add before I quit. Quite a number of years ago
23 it came out in the paper that anybody that had
24 leukemia, radiation didn't -- was -- didn't have a
25 thing to do with leukemia. And it was -- and it was

1 believed. People believed it. So this boy, that HEHF
2 doctor here, I don't know what his name was because he
3 wouldn't tell us, but we've -- from the plumbers and
4 fitters, we decided that we were going to -- wasn't
5 going to take 5,000 MR a year, we was only going to go
6 -- take 3,000. And so we had an awful time getting it
7 through, but they -- our international president said
8 no, you're going to take 5,000. I said well, come on
9 out and take it, if that's the way you want.

10 So anyhow, they -- we talked to a nurse.
11 She's dead now, God help her. She would come and take
12 blood samples of our people that was -- we were going
13 down in the -- like at 100-N, down in those holes, and
14 they get 300 MR in about eight minutes. So we would
15 take a blood sample of the boys that went down in those
16 holes and this doctor that came along, he brought his
17 microscope out and he would take this plate and make a
18 plate of the blood sample. They would go in and do
19 their job at high radiation and eight minutes, and come
20 out and we took another blood sample right after they
21 come out and he made a plate for it. And after looking
22 at -- a lot of people never looked in a microscope
23 before, but I have, and we looked at it -- at the
24 plates. And this doctor said you see that? When
25 you've got leukemia that's what your blood looks like.

1 So it was pretty much proven that radiation upset your
2 blood system, too. So what we did, too, we went a week
3 after that and took another blood sample of the same
4 people and their blood was back to normal again. So
5 that's where we came up with the 300 MR. That's all we
6 took.

7 So I just hope some time or other that they
8 start paying us to get back even again because -- oh,
9 one other thing. I just got a letter from them. I
10 complained to them about -- that they didn't have any
11 doctors or people that interview us from the Hanford
12 project, so they sent me a list of the people from --
13 they said all you've got to do is just put a circle
14 around the ones you want to talk to, so that's what
15 they did. And this one guy I talked to, he had never -
16 - he didn't even know what a tube reactor was. He'd
17 worked in labs all his life, you know. And so as I
18 say, they cooperate with you pretty well. But it's
19 been quite a few years since -- since this thing's been
20 going on and I hope I outlive the cancer. I don't know
21 whether I will or not, but -- but anyhow, I'm still
22 taking the shots. And these shots that they give you -
23 - any of the women in here that's over 50 years old
24 know what I'm talking about -- you have hot flashes.
25 Yeah, you do, you have hot flashes. And I mean -- so I

1 told the doctor, I said God, those hot flashes -- he
2 said oh, hell, I got a pill for that, so he give me
3 some pills for it. And also this thing that you're
4 taking, you take this shot and you -- these hot flashes
5 you have, your skin just burns up, you know, and -- but
6 you get red spots and green spots in front of your
7 eyes. That's what -- that goes with those shots. So
8 you -- so I'll tell you, it's -- it's quite a -- it's
9 quite a thing to go through that, and I just hope that
10 -- that they get their act together. They say they're
11 up in the million dollars now that they've give to
12 people in -- in the Hanford project. I hope they --

13 **DR. ZIEMER:** We had those discussions. Thank
14 you. Thank you.

15 (Applause)

16 **DR. ZIEMER:** I think they cover everything
17 but hot flashes, actually. Just -- thank you very much
18 for your comments.

19 The other gentleman that -- is over here,
20 yes.

21 **MR. DAVID:** My name is John David. I'm a
22 sheet metal worker. I'm fortunate enough right now to
23 represent the sheet metal workers here in this area,
24 sheet metal workers Local 66. And I think it's pretty
25 evident to anybody that's had an opportunity to hear

1 people speak here that this record -- dose
2 reconstruction just absolutely, totally does not work.

3 Now I can remember working out there where
4 this gentleman worked, and I can remember working with
5 that gentleman right there, and he's a sheet metal
6 worker and his father was a sheet metal worker. And
7 whether you're a sheet metal worker or a pipe fitter or
8 whatever you did out there, you took a whole lot of
9 dose. And it's pretty amazing to me that -- and I can
10 remember people called timekeepers, and that's all
11 their job was, they kept track of our dose. Now where
12 all these books went is pretty amazing to me because
13 they've got stacks of books everywhere out here and
14 they've got every record in the world. And I'll
15 guarantee you if I did something wrong out there, they
16 could find every record on me they -- and they could
17 probably replicate it in -- just like that. But when
18 it comes to finding out for these people's medical
19 issues, they can't find squat. Now there ain't nothing
20 -- you can't call it anything other than unadulterated
21 bullshit.

22 (Applause)

23 **MR. DAVID:** Thank you. And these people need
24 to be taken care of. Now I don't -- you guys can
25 travel all around the country, and I want to thank you

1 for coming here, I want you to know that, and every one
2 of us here want to thank you for that. But bottom
3 line, you've got to give these people what they have
4 coming, plain and simple. And they've put all this
5 paperwork together. They've done everything they're
6 supposed to do, and they're just waiting for somebody
7 to do what they're supposed to do.

8 And this gentleman here, Mr. Elliott, I've
9 had the opportunity to see him and his people come
10 through here, and his people that are sitting over
11 here, I've seen them and I've seen them here multiple
12 times. But hey, the rubber's got to meet the road
13 sooner or later. And people are not going to continue
14 to accept from you that hey, we're working on it,
15 because working on it just don't cut it. And so all
16 these people that are saying that they're trying to do
17 something, what are they trying to do?

18 Now I'm no genius. Okay? I went to two
19 years of community college and I went to an
20 apprenticeship, and I'm proud to tell you that. But I
21 can figure out that this site needs to be a special
22 cohort site, and I don't know how long it's going to
23 take your Advisory Board or the NIOSH or whoever else
24 it is to come up with that.

25 Now these people around the country, these

1 other sites, they've got that. And you're just going
2 to continually just talk to them and talk to them and
3 talk to them -- okay? -- and they're not going to get
4 anything and these people are dying, and that's
5 horrific.

6 Now I had the opportunity to work out there
7 for 14 years. I don't have anything wrong with me, I
8 don't think. Okay? So you -- you got -- you just got
9 to bite the bullet and accept that and create this --
10 make this a special cohort site. You can't beat around
11 the bush any more than you already have. You
12 determined now that you had your dose reconstruction
13 project complete in October of 2003. You can't prove
14 to anybody that you're getting anything done.

15 I'd also like to say that I happen to have
16 the opportunity to represent a gentleman that's had his
17 head opened up twice. Well, he's not eligible. He can
18 only go through the State of Washington LNI program.
19 Well, the last time it was, here last October, he got
20 his head opened up, that was \$250,000 to our health
21 care plan. That's the second time it's happened. Both
22 times, fortunately, the tumors are benign. He's not
23 eligible, and he's going to get some more of these
24 tumors 'cause he's got to go in every six months and
25 he's got to get checked. He's 50 years old. He's got

1 to have malignant tumors before he can get any money?
2 A quarter of a million dollars.

3 This gentleman over here says he's told that
4 hey, our health care plans will provide it -- provide
5 for us, and our health care insurance premiums are
6 going through the roof, which the government has a
7 responsibility to address this.

8 I also had an opportunity to work with a
9 gentleman that he came here at the last time Mr.
10 Elliott and his group of people were here, and he was
11 so serious about this that he told Mr. Elliott that you
12 could go exhume my dad's body right now, I'll give you
13 permission. My sister and I will do that. Because
14 there's no records of my father ever being
15 contaminated, and I will guarantee you you will find
16 plutonium in his system today. Now that's a pretty
17 serious thing when somebody would be willing to allow
18 their parent to be exhumed. And there's probably other
19 cases just like that.

20 Now I also would like to say and I'd like to
21 thank Eunice Godfrey and the people that are over in
22 that office that are trying to help these people of
23 this community, because they have one of the most
24 thankless jobs that I could ever imagine having. And
25 they do a fantastic job of working with what they have.

1 But you people and the people that are supposed to be
2 helping these people have got to do something to
3 actually come up with something. And so this gentleman
4 over here doesn't have to tell you about the horrific
5 medical expenses he's experienced and 86 years old,
6 which I'll go out on a limb and say it's pretty amazing
7 to me that he can afford that. And go back and tell
8 whoever it is you've got to tell wherever you've got to
9 tell, because apparently they're not here, that this
10 can no longer go on any longer.

11 And again and lastly, I'd like to thank you.
12 I know that everywhere you go you're probably hearing
13 the same story. I don't know if you get paid for what
14 you do or whatever, but whatever you're getting paid,
15 you're probably -- you're earning every penny of it.
16 But you're going to continue to get this until you
17 finally and -- give these people what they're asking
18 for, and that's simply just what they're supposed to
19 get. This program was created in 2000, said hey, come
20 on, sign up. And it's unacceptable to anybody that
21 here four years later we have these minuscule numbers
22 that we get a chance to read in the papers that we've
23 compensated people for. Comparative to the amount of
24 people that have applied for this program, it's -- I
25 don't think that you could -- anybody could really say

1 that it's done its job so far.

2 So again and lastly, thank you for coming and
3 please take this message back. Not for me, not for
4 you, for all these people and for all these people that
5 aren't here tonight that -- they have died and their
6 survivors are trying to get this compensation, and
7 thank you.

8 (Applause)

9 **DR. ZIEMER:** Thank you very much. Another
10 gentleman approaching the mike -- give us your name,
11 sir, and...

12 **MR. MITCHELL:** My name is J. L. Mitchell and
13 I worked out at the project for 33 and a half years. I
14 worked in all the areas and all buildings with various
15 types of material. In fact, the night that the plant
16 blew up, I was the one that ran the sample and I was
17 told that the samp-- we didn't have that much americium
18 in the project. And we pulled another sample and in
19 between the two, then she went -- the plant went. And
20 I got contaminated and so did the rest of the crew that
21 was there. We really got a shot of americium.

22 I also worked with the thorium and beryllium
23 and all of that over the period of time that I was in
24 the plant. And I -- we always wore badges, but the
25 badge only reads when it's coming directly to you. If

1 you have the badge pinned here and you turn this-a-way,
2 well, your body's getting the reading instead of the
3 badge. So it's not a -- really a true reading there,
4 and I was never satisfied with -- they put the air
5 sample up and then they'd take it down the next day and
6 they let it set 24 hours while it decayed before they'd
7 take the reading. But in the meanwhile, we was in the
8 lab all the time getting it all the time and we never
9 had no decay period. So there's really not a accurate
10 reading that -- I don't think, because if we had been,
11 it wouldn't be as many people is sick -- that are sick
12 from the -- the things that they went through out there
13 and they taken. And so I'm here to just let them know.
14 And as I read in the *Reader's Digest*, the article about
15 McCluskey was really not accurate because they left out
16 some things and I don't know who dictated to the
17 writer, but I'm the man that ran the sample and I'm the
18 one to know what happened. And I just want people to
19 know that that write-up wasn't really like it was
20 supposed to be because it was too much left out. I
21 don't know if it was covered over or left out, but it
22 really wasn't accurate. And I'm here because I would
23 like to get compensated for my sickness and for the
24 suffering and I put myself through. And if it's any
25 ways possible that I could get some help with this

1 reconstruction because I've been contacted by attorneys
2 from a southern state -- and I won't call the state --
3 about my sickness and they wanted to know was anybody
4 doing anything for me. And they asked me about the
5 asbestos and I didn't even know about it, and they said
6 they was in the area and took X-rays and I had
7 something in my lungs and they figured it was asbestos,
8 and this is what they was writing me about and they
9 wanted to get an answer from me. Well, I don't know
10 what it is, so what can I tell them? So I'm just kind
11 of between a rock and a hard place, but they keep
12 calling me and talking to me about it and they said if
13 -- if they don't do something about it pretty quick and
14 they was going to take over -- they was going to take
15 over the -- for my -- and be my attorney, and without
16 me even knowing what was going on. So I would, you
17 know, just like to know, is it other people outside the
18 state that know more about things than we do right here
19 in the tri-city area?

20 And I realize I been in Arkansas taking care
21 of my mother for about five years and I really haven't
22 kept up with everything because I wasn't here. And if
23 I had gotten any mail there and she got ahold to it,
24 ain't no telling what would have happened because she's
25 suffering with Alzheimer's. But really something

1 really needs to be done because it's a lot of people
2 out -- out here that worked out in that area and we got
3 a lot of radiation that we shouldn't have gotten. But
4 we got it and so what we going to do about it? And
5 thank you.

6 (Applause)

7 **DR. ZIEMER:** I have one more individual that
8 signed up. It's Hank Hartley. Hank Hartley?

9 **MR. HARTLEY:** Good evening. My name is Hank
10 Hartley. I did have the pleasure of serving on the
11 Hanford Health Effects subcommittee with Dr. Henry
12 Anderson for about six years. For about six and a half
13 years I have managed the Hanford building trades
14 medical screening program, and I wanted to touch on I
15 guess four subjects. I'll start out with Charlie.

16 I worked for Charlie many years ago, the pipe
17 fitter general foreman who came up here a little while
18 ago and talked. I was one of those young guys that
19 used to run down there and attach the chokers, and
20 Charlie would tell them to be careful of the shine.
21 Well, I didn't know what shine was, so we went over to
22 100-H one day to get some valves out and Charlie said
23 see that wall over there? I said yeah. He says you
24 got to run like a son of a gun and get over there --
25 and I did. And then we ran in and put the chokers on

1 and got it out.

2 Anyway, the only thing I've ever really had
3 is a little bit of skin cancer, which the doctors burn
4 off about every three months or so. A little acid fell
5 on my shoulder in the Purex building -- PNO galley --
6 and I had a cancer removed from it. It was about 30
7 years ago I got that on me. But anyway, so much for
8 that.

9 What Charlie was talking about is these guys
10 (Inaudible) shine. I have seen a lot of fellows that
11 are not even nearly Charlie's age that are gone -- of
12 all -- of all crafts, of all unions, of all workers of
13 all types, production and construction.

14 The other subject I wanted to talk about was
15 this dose reconstruction. So many times in the past I
16 wanted to know what my dose rate was or how much did I
17 get, and they never could really quite tell me. Now
18 hopefully -- I'm hoping that today they can establish
19 some way or some means of being able to tell us what
20 our dose assessment was. I don't know how they're
21 going to do that. Maybe if they have people that did
22 receive doses and you worked near them or in the same
23 building as them, maybe they can do it, I don't know.
24 I hope that they have means and methods of doing it.

25 The other thing I was going to talk about was

1 -- so many talk about -- people talk about the down-
2 winders. Well, you know, I had my doubts a little bit,
3 too, a long time ago. But time passed and I've
4 listened to a lot of people talk, especially Gail at
5 the meetings I attended, and Ken Staley and Mr. Samson.
6 And anyway, I've been married a few times, but I
7 married a lady that used to live out in the Waluke
8 Slopes. She got 47 acres out there. I told her to
9 sell the property. I don't even want to live near
10 that. But what happened out there, during the green
11 run there were people out there, innocent people living
12 out there just doing their thing, and there are areas
13 out there that has been documented where people
14 absolutely died for no real reason. And I'm talking
15 about like Ritzville, Connell, all the little outlying
16 lands that are down wind from Hanford.

17 Well, anyway, I didn't much believe a lot of
18 these stories until you actually, like in my case, get
19 married to someone and they talk about it. And there
20 were a lot of strange things that took place out there
21 with animals, vegetables, women drinking milk when they
22 were -- I don't know, six, seven, eight years old and
23 developing breast cancer. And those women that
24 couldn't tolerate milk from a cow drank goat's milk,
25 which was even worse. And I attended a meeting on that

1 up in Spokane, and that was documented about the green
2 run that got on the grass and the cows ate it and the
3 animals got it up.

4 Anyway, there was a fella that lived out near
5 Eltopia, he was a Navy SEAL, and he has kept records of
6 -- of deaths of people in and around the area that are
7 hard to explain, and mostly they were cancers. And a
8 lot of them didn't have cancer in their family, but
9 they lived out in the blocks, we call it, down wind
10 from Hanford, and they had pretty bad cancers.

11 Then there was this -- another individual who
12 -- he's about my age, I would say. He lived out on his
13 grandfather's farm when he was very young, and the
14 grandparents used to go out into the wheat stubble and
15 find weather balloons. And these weather balloons were
16 released about the same time as the green run and they
17 would come over and fall down into the wheat stubble.
18 Well, the folks would go out there and pick up the
19 balloon. It'd have a little note that says if found,
20 please return to your Federal government and tell us
21 where and when and what and how. They did.

22 They thought they were doing their duty to
23 their country, and they were. But by the same token,
24 they were sort of being -- I call it experimented on,
25 you know, what through this release through the

1 balloons and the green run stuff that went over the top
2 of them. Well, most of those people died of a strange
3 -- brain stem cancers and things like that. A lot of
4 those people died from it.

5 And I read about it where so many times it's
6 written off, saying oh, well, you know, they had to
7 have it somewhere. Or there's people that live other
8 places that get it; you know, you can't blame it on
9 Hanford. But why so many people in such a small little
10 area? I mean that becomes the question, to me; why so
11 many deformed animals in that area, vegetables, things
12 like that. It makes you wonder.

13 Now from my wife's property, which I don't
14 own, you walk up to the top of the hill and what are
15 you looking at? 100-N, 100-H, all the places that
16 Charlie told me to look out for when we were working
17 out there as a pipe fitter. So I just wanted to touch
18 on that, that the whole thing is related not only from
19 the workers at Hanford, but from the people that live
20 down wind from Hanford, and they suffered serious
21 consequences.

22 There were cases that I have noticed, having
23 been a construction worker, Hanford's Health Effects
24 and the building trades medical screening, where there
25 were sometimes -- all the people on one side of a

1 block, for example, in Ritzville, would die, but the
2 people on the other side didn't. Something to do with
3 the prevailing wind -- I mean who knows? I'm not a
4 scientist. But I wholly concur with David -- John
5 David who just got up from sheet metal, and I sincerely
6 hope that some good things come of these meetings. And
7 I just want to tie it all together, Hanford, down-
8 winders, all the people that have suffered one way or
9 another because -- perhaps because of a lack of
10 knowledge.

11 So many people are afraid to come to EEOICPA.
12 I refer a lot of people here from the medical
13 screening. They're afraid that they can't remember the
14 details or who they worked for or when or where or
15 what. But there are ways -- I want to let the public
16 know, there are ways of finding out where you worked
17 and who you worked for. It takes a little research,
18 pension records, Social Security, affidavits from other
19 people that worked around you.

20 Now Charlie -- speaking of Charlie, there are
21 many people who could use Charlie as a person who could
22 sign an affidavit for them, and I have signed myself
23 four or five affidavits for widows whom I worked with
24 their husbands in various areas. And now that I saw
25 Charlie again tonight, it brought it to mind. He might

1 be able to help with a lot of these other people who
2 are looking desperately for someone they worked for.
3 They come to me and they say gee, Hank, everybody I
4 worked with is dead. You know, he was right. They
5 have been dying at a rapid rate, and they're at that
6 age where they do naturally die at this time because a
7 lot of them are World War II vets. My father is dead.
8 He worked out there. A lot of those guys have passed
9 on and they're not around to do affidavits and say that
10 yes, I worked with this individual at 100-K, 100-D,
11 HHR, whatever, they were there. But I think Charlie
12 would be a good person who still has good faculties and
13 he could sign affidavits and help people to prove where
14 they worked, and that's one of the bugaboos that the
15 people are worried about.

16 I tell them, regardless of your fear, call
17 the resource center in Kennewick. Those ladies down
18 there will help you. They will help you with the
19 paperwork. They're very good at what they do. They're
20 personable. I've had many, many, many individuals come
21 back to my office and tell me how personable those
22 ladies were, how good they were, how they -- how
23 helpful they were and how resourceful they were. I
24 mean they really work hard. And personally, my hat is
25 off to Judy Goudy, Teresa Hammer, who are the

1 caseworkers there, and Eunice Godfrey, their manager.
2 I mean they -- those ladies have really done a great
3 job and I'm here to give them a hand.

4 (Applause)

5 **MR. HARTLEY:** I guess that's all I had to
6 say. This is kind of impromptu. I was kind of nervous
7 coming up here. Usually I can talk a little bit
8 longer, but I'll try and let Charlie be the longer
9 talker. Thank you.

10 (Applause)

11 **DR. ZIEMER:** Thanks, Hank. We are running
12 short of time, but there was another individual -- yes,
13 sir, if you would approach the mike and give your name.
14 Use the mike so our recorder can pick it up here.
15 Thanks.

16 **MR. YATES:** Yes, I'm Roy Yates and I'm an
17 electrician out at Hanford. And I did have colon
18 cancer and it was stopped, you know -- or caught before
19 it spread throughout my body, but I did have to take
20 nine months of chemo. And right now I have on stage of
21 osteoporosis. You know, they detected it in my back
22 and hip and the doctors, you know, point for a man to
23 have it at my age of 56, you know, it had to be the
24 chemo that affected the thyroid and -- but I'd like to
25 add a few notes here that -- I worked at Purex and at

1 the plutonium finishing plant and while I worked at
2 Purex, you know, I witnessed, you know, a lot of
3 inconsistencies, such as, you know, we had commingling,
4 and that was throughout the 300-- or 200 areas and --
5 and that the rad workers would routinely check, you
6 know, the code site, you know, for any contamination.
7 And during one check they up and found hot spots on our
8 chairs in our shop -- one of our chairs. And these are
9 the same chairs we sat in, you know, with our coming
10 and going-home clothes. And after that there, a couple
11 of our more rowdiest electricians, you know, complained
12 to DOE and at Purex we got that commingling stopped,
13 which made, you know, management kind of upset, but --
14 this was for taking breaks and stuff. It was fast to
15 get surveyed out of a zone and -- and not change out of
16 your whites.

17 And at the same -- as time went on, we ended
18 up finding contamination on our whites after not being
19 in anywhere where we should have got contamination, and
20 it came to be that we were getting hot coveralls back
21 from the laundry and -- so that was another episode
22 that -- all the stuff is probably -- no records kept of
23 it, you know, and Rockwell mission, you know, to its
24 managers, was do what it took to keep the plant
25 running.

1 And I was told as electrician at times to,
2 you know, do things that I thought was unsafe
3 electrically just to keep, you know, different
4 components running. And consulting with a radiation
5 technician that I worked with, both at Purex and then
6 moved on to the dash -- you know, plutonium finishing
7 plant, enlightened (sic) me with activities about their
8 equipment. They had monitors that, you know, they
9 turned off because they'd cause nuisance alarms, and
10 then they had inaccurate monitoring of records of other
11 monitors. Then they had -- these monitors also
12 consisted of aluminum parts, and when they had them in
13 the corrosive environments of -- of areas of Purex,
14 they -- they tend to fail that way. And I witnessed
15 this working on the equipment in those areas myself
16 that components were badly corroded. And so we were
17 exposed to another element right there with all the,
18 you know, toxics (sic) of the corrosions that went on.

19 And I guess -- like I said, I just -- I knew
20 this meeting was -- somebody told me this meeting was
21 coming up, but I didn't know about it until, you know,
22 just -- just this -- you know, earlier this evening, so
23 that's about as prepared as -- I did get my -- I did
24 record, you know, my -- my cancer, you know, into the
25 ONOSH (sic), you know, reporting. And I got my -- my

1 report back that said I was denied because I didn't
2 have, you know, the percentage it required. But I
3 still feel like under, you know, other testimonies and
4 -- and what I'm stating here that -- that we were
5 getting shines and other stuff that -- like I'd get
6 that shine, too, because we went to, you know, the
7 canyon where we had to work on the crane and the
8 component you were working on is what they would, you
9 know, kind of, you know, time kept what you were
10 facing. But in back of you, you had the crane hook
11 that was putting off a lot more dosage and a lot of
12 your monit-- or a lot of your timekeepers didn't
13 account for that, and that was coming from your back.
14 So there was other -- oh, various activities of this
15 nature that I feel like I didn't -- you know, what's on
16 my records, you know, probably didn't account for
17 everything that I was exposed to.

18 **DR. ZIEMER:** Thank you.

19 (Applause)

20 **DR. ZIEMER:** Thank you very much. Let's see,
21 Richard Miller, are you wanting to speak today yet
22 or --

23 **MR. MILLER:** (Off microphone) (Inaudible)

24 **DR. ZIEMER:** Okay. There will be an
25 opportunity again tomorrow for public comment.

1 Let me ask one final time, are there any
2 other individuals -- I know we've gone past our time --
3 was advertised as going to 8:30, but -- you have
4 another lady? Thank you very much.

5 **UNIDENTIFIED:** (Inaudible)

6 **DR. ZIEMER:** Okay, right. Well, let's give
7 this lady a chance and then you'll have the
8 opportunity...

9 **MS. VAN DYKE:** Hi, my name is Catherine Van
10 Dyke and I am not a public speaker so you'll have to
11 excuse me, but I've been feeling led throughout the
12 whole meeting tonight to get up here and share. I was
13 a quality control inspector out at Hanford for ten
14 years, and I quit to come home and take care of my
15 little boy and be an at-home mom. When I come home
16 from being employed out there, I worked at several
17 different areas out there, I had ongoing health
18 problems and was in communication with the journeyman
19 that I worked side-by-side with all those years who has
20 a cousin disease compared to what they were finding or
21 treating or still are currently treating me for.

22 He has scleroderma, which is a connective
23 tissue problem. They've been treating me with lupus,
24 but I've never really been textbook for anything. I
25 went and applied for the former Hanford checkup and I

1 am beryllium sensitized, which really took me by
2 surprise after many years of ongoing testing and
3 putting us in a financial situation of many medications
4 and many different testing. I am currently going to
5 National Jewish once a year. I go next month for lung
6 biopsies. I did have high lymphocytes showing and
7 everything. But my main concern this evening is to
8 mention to you -- and I do have a claim with you guys.
9 It has been approved as far as the beryllium
10 sensitivity goes for ongoing testing.

11 But I'd also like to have you take a look at
12 the fact of all my other health problems from all the
13 other things that I've been exposed with. I just
14 cannot seem to find a physician or someone to place it
15 all together as all the multiple problems that I have.
16 I am 45 years old and I am permanently disabled, and it
17 has been a real struggle for me. And I thank you for
18 coming and -- and I just want to make you aware of
19 where I'm coming from. Thank you.

20 **DR. ZIEMER:** Thank you.

21 (Applause)

22 **DR. ZIEMER:** Now this -- this is --

23 **MS. JAHNKE:** Louisa Jahnke.

24 **DR. ZIEMER:** Right, Louisa.

25 **MS. JAHNKE:** My husband worked out here for

1 40 years. He came -- he came out of the Marines, went
2 to work for Hanford. I have documented where he --
3 which building he worked in, every building he worked
4 in and what he done. He was exposed to asbestos,
5 beryllium, and I have papers on where there was two
6 accidents out there that he was in in radiation. And
7 this is the way he ended up, completely paralyzed.

8 I have letters from five doctors that said
9 they did not know what was wrong with him. They
10 couldn't diagnose beryllium or -- or anything that he
11 had. And if you men would look at this picture, I had
12 to change his diapers every hour. It was rough. Just
13 think if your wife had to do that for four years. But
14 I loved him, so I did it. And I just can't get no
15 place on these people. They won't do nothing for me,
16 and I'm still paying the hospital bills. Can you
17 imagine that? I'm still paying them. Social Security
18 don't go very far, so I sure wish you would do
19 something about this. I thank you.

20 And I want to tell you something. My kids
21 were all born and raised here. My youngest son, they
22 found beryllium in his lungs. He never worked out
23 there. He went to Seattle to Dr. Dakari, probably some
24 of you know him, and Dr. -- the doctor came down here
25 to Hanford. They found beryllium in his lungs from

1 Bill carrying it home on his shoes, washing the
2 clothing all together. That's what the doctor said.
3 Can you imagine that? So I wish you would take care of
4 at least one of these. I appreciate it. Thank you.

5 **DR. ZIEMER:** Thank you.

6 **MS. JAHNKE:** I made it.

7 (Applause)

8 **DR. ZIEMER:** Thank you very much, all who
9 participated and all who attended this evening. The
10 Board will be meeting again tomorrow. I should
11 emphasize to you, our meetings are completely open, not
12 just the public period. They may be a little boring at
13 times, they may be exciting, but you are welcome to all
14 the meetings tomorrow. There's a lot of information,
15 as one of the earlier gentlemen pointed out, our
16 various presenters providing the Board with information
17 to help us 'cause we are learning, too. And so you're
18 welcome to join us again tomorrow.

19 Our session begins -- what time does our
20 session begin? The formal part of the session will
21 begin at 8:30 and we continue through the day tomorrow.
22 There will be a public comment period in late morning
23 tomorrow, as well.

24 Again, thank you and good night.

25 (Meeting adjourned 8:50 p.m.)

C E R T I F I C A T E

STATE OF GEORGIA)
)
COUNTY OF FULTON)

I, STEVEN RAY GREEN, being a Certified Merit Court Reporter in and for the State of Georgia, do hereby certify that the foregoing transcript was reduced to typewriting by me personally or under my direct supervision, and is a true, complete, and correct transcript of the aforesaid proceedings reported by me.

I further certify that I am not related to, employed by, counsel to, or attorney for any parties, attorneys, or counsel involved herein; nor am I financially interested in this matter.

WITNESS MY HAND AND OFFICIAL SEAL this _____ day of May, 2004.

STEVEN RAY GREEN, CVR-CM
GA CCR No. A-2102

